

# PATIENT INFORMATION (PLEASE PRINT)

DATE \_\_\_\_\_

Please complete the entire form

PATIENT'S NAME					S.S.#		E-MAIL ADDRESS	
MARITAL STATUS			SEX		DATE OF BIRTH		AGE	
S	M	W	D	SEP	M	F	HOME PHONE#	
STREET ADDRESS					CITY AND STATE			ZIP CODE
PATIENT'S OR PARENT'S EMPLOYER					OCCUPATION (INDICATE IF STUDENT)			HOW LONG EMPLOYED
EMPLOYER'S STREET ADDRESS					CITY AND STATE			
REFERRED BY				HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE				
DRUG ALLERGIES, IF ANY								
SPOUSE OR PARENT'S NAME					RELATION TO PATIENT		SS#	
SPOUSE OR PARENT'S EMPLOYER					OCCUPATION (INDICATE IF STUDENT)			
IN CASE OF EMERGENCY CALL					HOME PHONE		BUSINESS PHONE	
PERSON RESPONSIBLE FOR PAYMENT IF NOT ABOVE					STREET ADDRESS, CITY, STATE			ZIP CODE
PRIMARY INSURANCE CARRIER & ADDRESS					NAME OF POLICY HOLDER & RELATION TO PATIENT			
STREET ADDRESS, CITY, STATE					POLICY #			GROUP #
SECONDARY INSURANCE CARRIER & ADDRESS					NAME OF POLICY HOLDER & RELATION TO PATIENT			
STREET ADDRESS, CITY, STATE					POLICY #			GROUP #
FAMILY PHYSICIAN				STREET ADDRESS, CITY, STATE, ZIP CODE				PHONE

**PLEASE READ:** All charges are due at the time services are performed. If insurance is to be filed the patient is responsible for furnishing insurance claim forms to the office. The patient is responsible for all fees, regardless of insurance coverage.

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DR. \_\_\_\_\_ TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_