PATIENT INFORMATION

Date _____ E-mail _____

Patient's Name _____

Responsible Party _____ Relationship _____

Street _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Date of Birth _____ Age _____ Gender: ❑ Male ❑ Female

Soc. Sec. # ____/____/____ Driver's License # _____

Employer _____

Which Doctor will you be seeing today? _____

INSURANCE INFORMATION

Do you have insurance: ❑ YES ❑ No Type: ❑ PPO ❑ Medi Care ❑ HMO

Insurance Company _____ Policy / Group No. _____

IF DIFFERENT FROM PATIENT

Name of Primary Insurance Holder _____

Insured's SS # ____/____/____ Date of Birth _____

SECONDARY INSURANCE INFORMATION

Do you have secondary insurance? ❑ YES ❑ NO

Insurance Company _____ Policy / Group No. _____

NEAREST RELATIVE NOT LIVING WITH YOU

Name _____ Relationship _____

Street _____ Phone # _____

City _____ State _____ Zip _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process any claim incurred. I authorize payment of medical benefits from either government or private insurance companies, to my physician, for any services provided. I understand that if the physician is not contracted with the above-listed insurance company, this office will be billing as a courtesy and that I am responsible for any unpaid charges. Office visits not cancelled 24 hours in advance may be subject to a $25.00 fee.

SIGNED: _____ DATE: _____

As a courtesy and service to our patients, we bill your insurance company free of charge. We will bill any deductibles or co-payments to your credit card directly.

❑ Visa ❑ Mastercard Card Number _____ Exp. Date _____

Signature _____