

# PATIENT INFORMATION

Welcome To Our Office

(PATIENT'S NAME PLEASE PRINT)

(FIRST)	(MIDDLE)	(LAST)	(GOES BY)	S.S. #	MARITAL STATUS	SEX	BIRTH DATE	AGE
					S   M   W   D   SEP   M   F	M   F	/   /	
MAILING ADDRESS			PERMANENT	TEMPORARY	CITY AND STATE		ZIP CODE	HOME PHONE #
PATIENT OR PARENTS EMPLOYER				HOW LONG EMPLOYED	PATIENT'S OCCUPATION (INDICATE IF STUDENT)			BUS. PHONE # EXT. #
EMPLOYER'S STREET ADDRESS				CITY AND STATE			ZIP CODE	
SPOUSE NAME				S.S. #				
SPOUSE EMPLOYER				OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS. PHONE #		
PATIENT STREET ADDRESS				CITY AND STATE			ZIP CODE	
SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED				CITY AND STATE			ZIP CODE	HOME PHONE #

**PERSON RESPONSIBLE FOR BILL (If different from patient - Step-Parents, Guardians, etc.)**

PERSON RESPONSIBLE FOR PAYMENT NAME	RELATIONSHIP TO PATIENT	S.S. #
MAILING ADDRESS	PERMANENT	TEMPORARY
CITY AND STATE		ZIP CODE
		HOME PHONE #

Cell Phone:	Emergency Contact: NAME & PHONE NUMBER:
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<b>PRIMARY INSURANCE INFORMATION</b> <i>(Person who insures is thru parents, spouse etc)</i>		INSURANCE NAME	
INSURED'S NAME (Last Name, First Name, Middle Initial)		INSURED DATE OF BIRTH	
		MM : DD : YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>
INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		POLICY #	GROUP #
INSURED'S ADDRESS (No., Street)		EMPLOYER'S NAME OR SCHOOL NAME	
CITY	STATE	INSURANCE PLAN NAME OR PROGRAM NAME	
ZIP CODE	TELEPHONE (INCLUDING AREA CODE)	IS THERE ANOTHER HEALTH BENEFIT PLAN?	
<b>SECONDARY INSURANCE INFORMATION</b>		INSURANCE NAME	
2ND INSURED'S NAME (Last Name, First Name, Middle Initial)		EMPLOYER'S NAME OR SCHOOL NAME	
2ND INSURED'S POLICY OR GROUP NUMBER		INSURANCE PLAN NAME OR PROGRAM NAME	
2ND INSURED'S DATE OF BIRTH		SEX	
MM : DD : YY		M <input type="checkbox"/> F <input type="checkbox"/>	

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITED INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH MANAGEMENT.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand insurance eligibility does not guarantee payment. I agree to abide by the rules of my insurance, PPO or HMO plan; and pay my co-insurance, co-pay or deductible amount at the time of my visit.

Signature \_\_\_\_\_ Date \_\_\_\_\_