PATIENT INFORMATION SHEET

Patient Name: _____Jr. / Sr. / III Marital Status: S M D W O
(Last) (First) (MI)
Address (Mailing): _____ City: _____

State: _____ Zip: _____ Physical Address (If Different): _____

Sex: M or F Date of Birth: _____ Social Security #: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Whom may we contact in case of emergency: _____ Relationship: _____

Phone: _____

Are there other members of the immediate family who have already been to this office? Y or N

If so, list their names: _____

INSURANCE INFORMATION

Primary Insurance Patient's Insurance ID#: _____

Subscriber (whose job provides plan?): _____
(Last) (First) (MI)
Subscriber's Date of Birth: _____Sex: M or F Subscriber's Social Security #: _____

Insurance Company: _____ ID #: _____ Group#: _____

Second Insurance? Y or N Patient's Insurance ID#: _____

Subscriber: _____
(Last) (First) (MI)
Subscriber's Date of Birth: _____ Sex: M or F Subscriber's Social Security #: _____

Insurance Company: _____ ID #: _____ Group #: _____

If there is a third plan, please put information on back. Is this related to a Motor Vehicle Accident or Worker's Comp ?

Ultimately, who is responsible for the bill (the Guarantor)?: _____

Address: _____

AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

If required, I hereby authorize payment directly to the physician responsible for my care. I understand that I am financially responsible to my physician for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third party payor in order to obtain payment. I hereby authorize the physician to release any medical information required for my examination or treatment. I understand that payment is expected at rendering of services unless other arrangements have been made. I hereby also consent to medical treatment for my present condition or injury, and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I understand that even if I have some type of insurance coverage, I am responsible for payment of services.

_____ _____
Signature of Responsible Party (relationship) Date