Patient Information

NAME: _____ DATE:_____
First Middle Last

MAILING ADDRESS: _____

CITY_____ STATE_____ ZIP CODE_____

PHONE NUMBERS: HOME:_____ CELL:_____ CELL CARRIER:_____

DATE OF BIRTH: _____ AGE: _____ MALE / FEMALE

SOCIAL SECURITY NUMBER: _____ E-mail: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

MARTIAL STAUS: Single Minor Married Divorced Separated Widowed Partnered for _____ years

EMERGENCY CONTACT (1)_____ PHONE NUMBER:_____

(2)_____ PHONE NUMBER:_____

If you are a minor, PERSON WHO IS RESPONSIBLE FOR YOUR ACCOUNT:_____

RESPONISBLE PARTY'S SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY'S ADDRESS: _____

_____

PRIMARY INSURANCE

NAME OF INSURANCE: _____

CONTRACT NUMBER: _____ GROUP NUMBER:_____

NAME ON CONTRACT:_____

RELATIONSHIP TO CARDHOLDER:_____ CARDHOLDER'S DATE OF BIRTH:_____

SECONDARY INSURANCE

NAME OF INSURANCE: _____

CONTRACT NUMBER:_____ GROUP NUMBER:_____

NAME ON CONTRACT: _____

RELATIONSHIP TO CARDHOLDER: _____CARDHOLDER'S DATE OF BIRTH:_____

***If you insurance coverage is through your spouse or parent's employment, please give the following:

NAME:_____

PLACE OF EMPLOYMENT:_____ TELEPHONE NUMBER:_____

ASSIGNMENT AND RELEASE

I understand that if my insurance company requires a co-payment for services, I will pay it at the time of my visit.

I hereby authorize release of medical information from my physician as it may be necessary for completion of my insurance claim and continuing medical treatment.

***I understand that it is my responsibility to make sure the physician is a participating provider covered under my insurance plan. I understand if they are not providers, the office will file with my insurance, but any unpaid portion of my bill is my responsibility (i.e. out of network charges, deductibles, etc.). I am responsible for notifying the nurse or receptionist where blood work (lab) needs to be sent for testing (examples: Lab Corp, DCH). I am responsible for changing my primary care physician if my insurance requires a PCP. I understand I am responsible for making sure if I need a referral to the hospital, ER, or other physician (not scheduled by PCP office), I will notify the office within 72 hours or no referral will be done.

I hereby authorize direct payment to the physician. I am responsible for my copays and for any services rendered that are not covered by my insurance. I understand that these noncovered charges are my financial responsibility. I understand that if I do not fulfill my financial obligations that I can be turned over to a collections agency and any collection and/or attorney fees assessed to my account are my responsibility.

SIGNATURE:_____DATE:_____

****I am aware that I am to give the office a 24 hour notice upon cancellation of my appointment. I understand that if I miss my appointment without notice of cancellation I will be billed $30.00 for no showing for my appointment. I also understand that my insurance company cannot be billed for this and I will be responsible for payment of these charges.

SIGNATURE:_____DATE:_____