PATIENT INFORMATION FORM

PLEASE PRINT

Name _____ _____ ____
Last First M.I.

Mailing Address_____

_____ _____ _____
City State Zip

Home Phone _____ Cell Phone _____

Work Phone _____

Date of Birth _____/_____/_____ SS# _____

Male _____ Female _____ Marital Status M S W D

In case of emergency, who should be notified? _____

Relationship _____ Phone _____

Referred by_____ **Primary Care Physician**_____

INSURANCE INFORMATION (Please present insurance card at time of check-in)

Primary Insurance Name _____

Name of Insured _____ Relationship to insured (circle) Self Spouse Parent

Insured Date of Birth _____/_____/_____ Insured SS# _____

Insurance ID # _____ Group # _____

Secondary Insurance Name _____

Name of Insured _____ Relationship to insured (circle) Self Spouse Parent

Insured Date of Birth _____/_____/_____ Insured SS# _____

Insurance ID # _____ Group # _____

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I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient signature_____ Date ____/____/____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is expected from you at the time of service for applicable co-payments as defined by your insurance carrier. We accept payment in the form of cash, check, or credit card. If you are unable to pay your co-pay at the time of your visit, it is expected within 30 days or you will be subject to a $5 surcharge for each monthly billing. Your signature below signifies your understanding and willingness to comply with this policy.

Patient signature_____ Date ____/____/____

Please present insurance cards to the receptionist so copies can he made.

Do we have your permission to: (please answer all of the following questions)

1) Leave a message on your answering machine at home? YES NO N/A

2) Can we call you on your cell phone or leave a message? YES NO

3) Leave a message at your place of employment? YES NO N/A

4) Discuss your medical condition with any member of your household? YES NO

If yes, with whom?

_____ relationship _____

_____ relationship _____

_____ _____

PATIENT SIGNATURE **DATE**