PATIENT INFORMATION

THANK YOU FOR CHOOSING OUR OFFICE!
IN ORDER TO SERVE YOU PROPERLY WE NEED THE FOLLOWING INFORMATION:
PLEASE PRINT ALL INFORMATION WILL BE CONFIDENTIAL

PATIENT NAME: ____________________________ DATE____________________________
SOCIAL SEC#: ____________DOB: _____________ HOME PH#: ______________________
ADDRESS: _______________CITY: ______________STATE: ___________ZIP: __________
PARENTS NAME: _____________________________WORK PH#: _____________________
WHOM MAY WE THANK FOR REFERRING YOU: _________________________________
EMERGENCY CONTACT: _____________________PHONE: __________________________

RESPONSIBLE PARTY

NAME OF PERSON FINANCIALLY FOR THE ACCOUNT: ____________________________
RELATIONSHIP TO PATIENT: _____________________DOB: ________________________
ADDRESS: ____________________________CITY: ______________STATE ______________
ZIP: _________ E-MAIL ADDRESS: ____
EMPLOYER: ____

INSURANCE INFORMATION

NAME OF INSURED: __________________RELATION TO PATIENT: __________________
BIRTHDATE: _________________________SOCIAL SEC#: ____________________________
NAME OF EMPLOYER: ____
INSURANCE COMPANY: _________________________GRP#: _________________________
INSURANCE ADDRESS: ____
CITY: ________________STATE:____________________ZIP:__________________________
EFFECTIVE DATE OF COVERAGE: _______________CO-PAY AMOUNT: ______________

DO YOU HAVE ANY OTHER INSURANCE YES/NO

IF YES PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED: ____________________RELATION TO PATIENT: _________________
DOB: _________________SOCIAL SEC#: ____
NAME OF EMPLOYER: ____
INSURANCE COMPANY: ____
INSURANCE ADDRESS:____
CITY: _______________________ STATE: _______________ZIP: ________________________
EFFECTIVE DATE OF COVERAGE: ________________CO-PAY AMOUNT: _______________

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTHCARE, ADVICE AND TREATMENT PROVIDED FOR THE PUROSE OF EVALUATING AND ADMINSERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OR INSURANCE BENEFITS OHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

X____DATE: ____________________
(SIGNATURE OF PATIENT (OR PARENT OF MINOR)