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Patient Information

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Gender: O Female O Male Date of Birth: _____

Check appropriate box: O Partner O Single O Married O Divorced O Widowed O Separated O Partner

Phone: Home: _____ Work: _____ Cell: _____

Number easiest to contact you to leave messages: _____ Email address: _____

HIPAA regulations require permission to leave detailed messages. Which number is best for this? _____

Spouse/Partner or parent's name: _____ Phone: _____

Patient's or parent's employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

If patient is a student, name of school/college: _____ City: _____ State: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship: _____

Address: _____ Home Phone: _____

Driver's license #: _____ Birthdate: _____ Financial Institution: _____

Employer: _____ Work Phone: _____

Is this person currently a patient at our office? O Yes O No

Insurance Information

Insured's name: _____ Relationship to patient: _____

Date of Birth: _____ Social Security Number: _____

Insurance company & ID # AS SHOWN ON CARD: _____ Group #: _____

Employer of Insured: _____ Phone: _____

What is your deductible? _____ How much have you used? _____

Do you have any additional insurance? O Yes O No

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

X_____ Date: _____

Signature of patient or parent if minor