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ABOUT YOU

Today's Date: _____ / _____ / _____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: _____ / _____ / _____ Age: _____ SS#: _____

Mailing Address: _____
CITY STATE ZIP

Home Phone #: (____) _____

Work Phone #: (____) _____ Ext: _____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____
CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

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IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

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INSURANCE INFO

Primary Insurance
 Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____ / _____ / _____

Insured's Employer: _____
 Please provide any Primary/Secondary Insurance cards with this form.

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment method: Cash Check

_____ / _____ / _____
 Credit Card - Enter card # above (if accepted)

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
 - ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
 - ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
 - ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials

Signature

Adult Patient Parent or Guardian Spouse

Date

UPDATE
(OFFICE USE)

Initials / /
Date

Comments

Initials / /
Date

Comments

Initials / /
Date

Comments