PATIENT INFORMATION SHEET

Name: ____
Last First Middle Initial

Date of Birth: ________________ Social Security No.: ________________

Sex: male / female Referred By: ____________________

Home Address: ____
Street City Zip

Home Phone: ________________ Cell Phone: ____________________

Employer: ____________________ Work Phone: ________________

Work Address: ____
Street City Zip

Email: ______________________________________

Marital Status: Single / Married / Divorced / Separated / Widowed

Emergency Contact Information:

Name: ______________________________ ____________________
Relationship to Patient

Home Address: ____
Street City Zip

Home Phone: ____________________ Work Phone: ________________

Cell Phone: ____________________

Primary Insurance: ______________________________________

Certificate/ID #: ____________________ Group #: ________________

Secondary Insurance: ______________________________________

Certificate/ID #: ____________________ Group #: ________________

AUTHORIZATION

I hereby consent to any necessary medical treatment/physical examination required for myself.

ASSIGNMENT

I permit payment directly to Dr.s Office any benefits due for the services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

MEDICAL RECORDS

Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We can not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature: ______________________________________ Date: ____________

Revised: 04/04/2014

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