PATIENT INFORMATION FORM

PATIENT INFORMATION:

Full (legal) Name: _____

Address: _____

City: _____

State/Zip: _____

Phone #:_____Cell #_____

Email: _____

Date of Birth: _____ Marital Status: _____

Driver's License #: _____

SS#: _____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____

Employer Address: _____

_____

Employer Phone #: _____

SPOUSE :

Full Name:_____

Employer:_____

Employer Phone#:_____

SS#:_____DOB:_____

Cell #: _____

Whom may we contact in case of emergency?

_____

Phone#:_____

Nearest Relative not living with you?

_____

Phone#:_____

Referring Physician: _____

_____

PRIMARY INSURANCE INFORMATION:

Insurance Co. Name: _____

Phone #: _____

Insured's Name: _____DOB_____

Policy #: _____ Group #: _____

Address Where Claims are to be mailed: _____

_____

_____

SECONDARY INSURANCE INFORMATION:

Insurance Co. Name:_____

Phone #: _____

Insured's Name:_____DOB:_____

Policy #:_____Group#:_____

Address where claims are to be mailed: _____

_____

_____

Please check (✓) which method would be best to contact you for an appointment reminder?

☐ Home phone ☐ Cell phone ☐ TEXT Message ☐ Work phone ☐ Email ☐ Regular mail

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I authorize the release of medical or other information about me to the above listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Copays, co insurance, and/or deductibles are due at time of service unless other arrangements have been made. All accounts should be paid within 90 days of insurance being posted to prevent further action. I agree to pay any collection or attorney fees owed in addition to court costs if charges are not paid within the agreed upon terms and legal action is necessary to effect collection.

I certify that I have read all of the above and the information given is true.

Patient Signature: _____ Date:_____