PATIENT INFORMATION

Patient Name: _____
First M.I. Last
Address: _____
City: _____ State: _____ Zip: _____
Home Phone ( ) _____ Work Phone ( ) _____
Cell Phone ( ) _____

Sex: ☐Male ☐Female Date of Birth: _____/_____/_____ Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed ☐Separated

Patient Social Security #: _____
Do you have immediate family members who are patients here?: _____
Place of Employment: _____ Job: _____
Employer Address: _____

If married,

Spouse Name: _____ Spouse Date of Birth: ____/_____/_____
Spouse Employer: _____ Address: _____

If minor,

Parent(s) Name: _____ & _____
Address if different than patient:
_____
_____
Phone if different than patient:
( ) _____ ( ) _____
Parent employer: _____ _____
Parent work phone: ( ) _____ ( ) _____
Person responsible for account: _____ Relationship to patient: _____

INSURANCE (Please allow office staff to copy your insurance card)
Primary Insurance Company: _____
Policyholder Name: _____ Date of Birth: _____ SS#: _____
Secondary Insurance Company: _____
Policyholder Name: _____ Date of Birth: _____ SS#: _____

EMERGENCY CONTACT: _____
Phone #: _____ Relationship: _____

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

X _____ Date: _____
Patient Signature (or parents, if minor)