

PATIENT INFORMATION SHEET

Today's Date: _____

Patient's Name: _____ Sex : (M) (F) Date Of Birth: _____

Address: _____
STREET ADDRESS CITY STATE ZIP

Social Security #: ____ - ____ - _____ Home Phone:(____) _____ Cell/Pager(____) _____

Currently Employed? (Yes) (No) Employer: _____ Work(____) _____

Fulltime Student? (Yes) (No) Patient's Martial Status: Single Married Separated Divorced Widowed

Name of your primary care physician: _____

Name of the nearest relative not living with you or a close friend we can contact incase of an emergency

Name: _____ Relationship: _____

City/State: _____ Home# _____ Work# _____

INSURANCE INFORMATION

If the patient is NOT the policy holder for the medical insurance, please complete this section

Policy Holder's Name: _____ Social Security #: ____ - ____ - _____

Address: _____ Date Of Birth _____
STREET ADDRESS CITY STATE ZIP

Employer: _____ Work # _____

To properly file with your insurance company, we need a copy of your insurance card. If we have not received a copy within one week from the date of service, you will be responsible for any out standing charges

Name Of Health Insurance: _____ Insurance Phone # _____

Claims Address: _____

Group # _____ ID# _____ Copay _____

Patient Waiver

If I do not have my referral in place BEFORE services are received, I understand that the services ARE NOT COVERED by my insurance and that I am responsible for payment of ALL CHARGES related to my visit.

Patient Signature: _____

Insurance Authorization And Assignment

I authorize payment of medical benefits to the undersigned physician or supplier for these services. I futher authorize the release of any medical information necessary to process this claim.

Patient Signature: _____