PATIENT INFORMATION *(Please Print)* Today's Date: ____/____/_____

Name: _____
Last *First* *M.I.*

Mailing Address: _____
City *State* *Zip*

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Area Code *Area Code*

Date of Birth: ____/____/____ Age: _____ Sex: ____ Marital Status: _____ SS#: _____

Email: _____

PARENT OR RESPONSIBLE PARTY *(If different from patient)*

Name: _____
Last *First* *M.I.*

Mailing Address: _____
City *State* *Zip*

Home Phone: _____ Work Phone: _____ Email: _____
Area Code *Area Code*

Date of Birth: ____/____/____ Age: _____ Sex: ____ Marital Status: _____ SS#: _____

INSURANCE INFORMATION (*Please present insurance card at time of check in.*)

Primary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group # _____

Employer Name _____

Employer Address _____

Employer Phone _____
Area Code

Relationship of patient to the Insured _____

Secondary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group # _____

Employer Name _____

Employer Address _____

Employer Phone _____
Area Code

Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified _____ Phone _____

Referred by: _____

Primary Care Physician _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Resposible Party Signature _____ Date ____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____/_____/_____

□ **Copy of insurance card (both sides) attached.** □ Updated By: _____