

PATIENT INFORMATION SHEET - PLEASE COMPLETE IN ITS ENTIRETY

(All information is necessary to bill your insurance for you)

DATE: _____

LEGAL NAME - FIRST: _____ LAST: _____ MI _____

DO YOU WISH TO BE ADDRESSED BY ANOTHER NAME? IF YES, INDICATE NAME: _____

STREET: _____ APT.# _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # () _____ DRIVER'S LICENSE: _____ EXP. DATE: _____

IF WE CAN FAX AND/ OR E-MAIL MATERIAL TO YOU, PLEASE GIVE US YOUR FAX AND/ OR E-MAIL ADDRESS:

CELL#: () _____ FAX# () _____ E-MAIL _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ SEX: F M

EMPLOYER: _____ TITLE: _____

EMPLOYER ADDRESS: _____

WORK PHONE #: () _____ MARRIED SINGLE DIVORCED WIDOWED

YOUR PRIMARY CARE PHYSICIAN: _____ PHONE #: () _____

WHO REFERRED YOU TO OUR OFFICE? DR. / MR. / MRS. / MS. _____

IF REFERRED BY MD, LIST NAME: _____ ADDRESS: _____ PHONE: _____

IF NOT REFERRED, HOW DID YOU FIND OUT ABOUT US? _____

INSURANCE INFORMATION: (PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT)

IF YOU DO NOT HAVE PROOF OF INSURANCE, PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED

MEDICARE # (IF APPLICABLE): _____

PRIMARY INSURANCE ID #: _____ GROUP #: _____ INSURANCE CO: _____

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)

FIRST NAME: _____ LAST: _____ MI: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

EMPLOYER: _____ DRIVER'S LICENSE #: _____

RELATIONSHIP TO PATIENT: _____ SPOUSE'S NAME: _____ SPOUSE'S D.O.B.: _____

IN CASE OF EMERGENCY:

NOTIFY: _____ PHONE # () _____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE DOCTOR WHOSE NAME APPEARS ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A \$5.00 MONTHLY FEE FOR BILLING SERVICE. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME THE SERVICE IS RENDERED IF I DO NOT PRESENT WITH A VALID INSURANCE CARD. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT IF MINOR) _____ DATE: _____