PATIENT INFORMATION

Thank you for choosing our office! In order to service you properly, we need the following information. ***Please Print****. All information will be kept confidential.* ***Please complete the entire form. Thank you for your cooperation.***

FULL LEGAL NAME:_____NICKNAME:_____

SS#_____DATE OF BIRTH: _____email address:_____

HOME ADDRESS:_____CITY:_____STATE:_____ZIP:_____

MAILING ADDRESS IF DIFFERENT:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

EMPLOYER:_____ADDRESS:_____

SEX: M/F_____MINOR:_____MARITAL STATUS:_____RACE:_____

IF MINOR:

NAME OF RESPONSIBLE PARTY:_____RELATIONSHIP:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

EMPLOYER:_____ADDRESS:_____

HOME PHONE#_____WORK#_____

EMERGENCY CONTACT:_____PHONE:_____

PRIMARY INSURANCE:

INSURANCE COMPANY:_____ID#_____GROUP:_____

WHO IS THE POLICY HOLDER:_____RELATIONSHIP:_____

DATE OF BIRTH:_____SS#_____EMPLOYER:_____

SECONDARY INSURANCE:

INSURANCE COMPANY:_____ID#_____GROUP_____

WHO IS THE POLICY HOLDER:_____RELATIONSHIP:_____

DATE OF BIRTH:_____SS#_____EMPLOYER:_____

TO ENSURE THAT WE HAVE THE CORRECT INSURANCE ADDRESS AND NETWORK, PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS.

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (MY CHILD'S) HEALTH CARE, ADVISE, ADVISE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I HEREBY AUTHORIZE PAYMENT OF ALL INSURANCE BENEFITS (INCLUDING MEDIGAP) OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

X_____DATE:_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN