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:_____

NEAREST RELATIVE:_____PHONE:_____

IF MINOR:
NAME OF RESPONSIBLE PARTY_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER:_____ADDRESS:_____

HOME PHONE #_____WORK #_____

PRIMARY INSURANCE:

NAME OF POLICY HOLDER:_____RELATIONSHIP_____

DATE OF BIRTH_____SS#_____EMPLOYER:_____

INSURANCE COMPANY:_____ID#_____GROUP#_____

SECONDARY INSURANCE:

NAME OF POLICY HOLDER:_____RELATIONSHIP_____

DATE OF BIRTH:_____SS#_____EMPLOYER:_____

INSURANCE COMPANY:_____ID#_____GROUP#_____

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 AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I HEREBY AUTHORIZE PAYMENT OF ALL INSURANCE BENEFITS (INCLUDING MEDICAP) OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

X_____DATE:_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN