

PATIENT INFORMATION

(please print)

Date: ___/___/___

Name (Last, First, MI)

Mailing Address (Street, Apt., City, State, Zip Code)

Home Phone _____ Work Phone _____ Cell _____

SS# _____ Date of Birth ___/___/___ Age ___ Sex ___ Marital Status _____

Employer _____ Occupation _____

OTHER ADDRESS or PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name (Last, First, MI)

Mailing Address(Street, Apt., City, State, Zip Code)

Home Phone _____ Work Phone _____ Cell _____

SS# _____ Date of Birth ___/___/___ Sex _____ Relationship: _____

Employer _____ Occupation _____

INSURANCE INFORMATION *(please present insurance card at time of check-on)*

Primary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group # _____

Employer Name _____

Employer Address _____

Employer Phone _____

Relationship of patient to insured _____

Secondary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group # _____

Employer Name _____

Employer Address _____

Employer Phone _____

Relationship of patient to insured _____

Other family member that are patients _____

Pharmacy of choice _____ Phone _____

In case of an emergency, who should be notified ? _____ Phone _____

Referred by: _____

I authorize the release of medical information to my 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.

By signing below, I state that the above information is true and correct. I will inform this office of any changes that are made as they occur.

Patient or Responsible Party Signature:

Date ___/___/___