PATIENT INFORMATION

PATIENT NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

ZIP CODE:_____ **CITY:**_____ **STATE:**_____

HOME PHONE: (_____**)** _____-_____ **WORK PHONE: (**_____**)**_____-_____ **CELL PHONE: (**_____**)**_____-_____

E-MAIL ADDRESS:_____**DATE OF BIRTH:** _____/_____/_____

SOCIAL SECURITY NUMBER: _____-_____-_____ **SEX: MALE FEMALE**

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO INSURED PARTY: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN / INTERNIST:_____ **REFERRED BY:**_____

PATIENT'S EMPLOYER INFORMATION: COMPANY_____

OCCUPATION:_____**CITY:** _____

SUPERVISOR:_____ **PHONE: (**_____**)** _____-_____

IS CONDITION ACCIDENT RELATED: YES NO DATE OF ACCIDENT: _____/_____/_____

WORK RELATED: _____ **AUTO:** _____ **OTHER** _____

DO YOU HAVE AN ATTORNEY OR DO YOU PLAN ON OBTAINING ONE? YES NO

ATTORNEY NAME:_____ **PHONE: (**_____**)** _____-_____

INSURED PARTY INFORMATION (SPOUSE OR PARENT)

INSURED PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS:_____
STREET CITY STATE ZIP

HOME PHONE: (_____**)** _____-_____ **WORK PHONE: (**_____**)** _____-_____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY:** _____-_____-_____ **SEX: MALE FEMALE**

EMPLOYER INFORMATION:
COMPANY:_____ **CITY:** _____

SUPERVISOR: _____ **PHONE: (**_____**)** _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

BILLING ADDRESS: _____**PHONE #: (**_____**)** _____-_____

SUBSCRIBER ID #:_____**SUBSCRIBER IS: SELF SPOUSE PARENT**

GROUP NAME: _____**GROUP #:**_____

COPAYMENT AMOUNT:_____ **INSURED PARTY DATE OF BIRTH:** _____/_____/_____

SECONDARY INSURANCE COMPANY: _____

BILLING ADDRESS: _____**PHONE #: (**_____**)** _____-_____

SUBSCRIBER ID #:_____**SUBSCRIBER IS: SELF SPOUSE PARENT**

GROUP NAME: _____**GROUP #:**_____

COPAYMENT AMOUNT:_____ **INSURED PARTY DATE OF BIRTH:** _____/_____/_____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and other pertinent information.

YOU ARE RESPONSIBLE FOR ALL CO-PAYMENTS, DEDUCTIBLES AND CHARGES NOT COVERED BY INSURANCE.

Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes:

diagnostic, insurance, legal and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained, by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED:_____ DATE: ____/____/_____

PATIENT, PARENT OR GUARDIAN

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME:_____

PHONE NUMBER: (_____) _____--_____ RELATIONSHIP: _____

ADDRESS:_____

CITY:_____**STATE:** _____ **ZIP:**_____