PATIENT INFORMATION

PLEASE PRINT

PATEINT: Cell # ( )

Last First MI Home # ( )

Patient's Home Address City State Zip

Patient's Billing Address City State **ZIP**

Social Security # Date of Birth Age Driver's License #

Patient's Employer Work Address Work #

Spouse's Name Spouse's Employer Work #

Emergency Contact:
(Local Friend or Relative) Name Address Phone #

REFERRED TO THIS OFFICE BY: _____

WHO IS YOUR PRIMARY PHYSICIAN? _____PHONE # _____

INSURANCE: PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES THAT COVER THIS PATIENT

PRIMARY: Insurance Company Name Policy #

Policy Holder's Full Name DOB

Policy Holder's Employer Name & Address

Policy Holder's Phone # Policy Holder's Work #

SECONDARY: Insurance Company Name Policy #

Policy Holder's Full Name DOB

Policy Holder's Employer Name & Address

Policy Holder's Phone # Policy Holder's Work#

Medicare # (Please Include Letter)

Medicaid #

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance.

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical / surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by insurance including fees associated with collections for unpaid balances. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

SIGN HERE _____ **DATE** ___ _____