PATIENT INFORMATION FORM

PATIENT NAME:_____ DATE_____

Address:_____

City:_____ Zip_____

Hm. Ph:_____ Wk. Ph:_____

Cell Ph:_____ Birthdate:_____

Sex:__ Marital Status:___ DL#_____ S.S.#_____

BILLING PARTY INFORMATION

Name:_____ Birthdate:_____

Address:_____ City:_____

SS#_____

Employer:_____ Wk. Phone:_____

SPOUSE (if applicable)

Name:_____ Birthdate_____

Address:_____ City_____

SS#_____

Employer:_____ Wk. Phone:_____

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION

Company:_____

Group or Policy #_____

REFERRED BY:_____

We accept MC/VISA, American Express, local checks and cash. Payment is expected at the time services are rendered. ***Please retain your invoices for insurance/tax purposes. You will be given the original at the time of the visit. There will be a charge for additional copies.....Thank You***

Pharmacy Name_____ Phone_____

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for non-covered services.

SIGNED:

(Patient, or Parent , if Minor) _____ Date_____

RELEASE: I authorize the undersigned physicians to release any information required to process INSURANCE CLAIMS.

SIGNED:

(Patient, or Parent, if Minor)_____ Date_____