

PATIENT INFORMATION FORM

PATIENT INFORMATION:

Full (legal) Name: _____
Address: _____
City: _____
State/Zip: _____
Phone #: _____ Cell #: _____
Email: _____
Date of Birth: _____ Marital Status: _____
Driver's License #: _____
SS# _____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____
Employer Address: _____
Employer Phone #: _____

PRIMARY INSURANCE INFORMATION:

Insurance Co. Name: _____
Phone #: _____
Insured's Name: _____ DOB: _____
Policy #: _____ Group #: _____
Address Where Claims are to be mailed: _____

SPOUSE :

Full Name: _____
Employer: _____
Employer Phone#: _____
SS# _____ DOB: _____
Cell #: _____

Whom may we contact in case of emergency?

Phone#: _____

Nearest Relative not living with you?

Phone#: _____

Referring Physician: _____

SECONDARY INSURANCE INFORMATION:

Insurance Co. Name: _____
Phone #: _____
Insured's Name: _____ DOB: _____
Policy #: _____ Group#: _____
Address where claims are to be mailed: _____

Please check (✓) which method would be best to contact you for an appointment reminder?

Home phone Cell phone TEXT Message Work phone Email Regular mail

I authorize the release of medical or other information about me to the above listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Copays, co insurance, and/or deductibles are due at time of service unless other arrangements have been made. All accounts should be paid within 90 days of insurance being posted to prevent further action. I agree to pay any collection or attorney fees owed in addition to court costs if charges are not paid within the agreed upon terms and legal action is necessary to effect collection.

I certify that I have read all of the above and the information given is true.

Patient Signature: _____

Date: _____

This practice is required to provide quality reporting data to the government. You can choose to opt out to exclude yourself. Otherwise, you choose to share your information. OPT OUT _____ (initial)