PATIENT INFORMATION

Please complete the following information. Please print clearly.

Referred by:
Doctor (name)_____, **Ad (where)**_____**Other**_____

Patient name_____ Sex: M□ F□ Date_____

SS#_____ Birthdate_____ Email Address_____

Home phone_____ Cell phone_____ Work phone_____

The office may contact/message me in the following manner: Home□ Cell □ Work □ Email □

Address_____City_____State_____Zip_____

Check appropriate box : □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

If patient is under 18, responsible party or parent please complete the following:

Parent/Responsible party name_____ Employer_____

Work Address_____

Parent SS#_____Parent Phone #_____

Home Address_____City_____State_____ Zip_____

Primary Insurance

Insurance Type_____ Group #_____ Contract #_____

Subscriber Name_____ Subscriber Birthdate_____

Subscriber SS#_____Relationship to patient_____

Subscriber's employer_____ Subscriber phone_____

Deductible_____ Copay for specialist visit_____

Secondary Insurance :

Insurance Type_____ Group #_____ Contract #_____

Subscriber Name_____ Subscriber Birthdate_____

Subscriber SS#_____Relationship to patient_____

Subscriber's employer_____ Subscriber phone_____

Deductible_____ Copay for specialist visit_____

I authorize release of any information concerning my (or my child's or parent's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible to pay for services rendered, and that I will be held responsible for any charges not covered by my insurance. I understand that I am responsible to pay for costs of collection and reasonable attorney's fees in the event of default. I further understand that if a payment becomes 60 days past due, delinquency fees at the rate of 30%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

X_____ _____

Signature of patient or parent/guardian/responsible party Date