PATIENT INFORMATION SHEET

(Please print clearly and fill out completely.) Date: _____/_____/_____

E-mail address:

Name of Patient:
Last First Middle

Mailing Address:
Street Apt# City State Zip

Home Telephone No. (_____)_____-_____ Cell No. (_____) _____-_____ Occupation: _____

Social Security No. Birth Date: Age: Sex:

Employer's Name: Phone No. ( ) -

Employer's Address:

Wife, Husband, or Parent Name: S.S.of Spouse:

Employed at: Phone no. ( ) Spouse DOB:

Address:

Nearest Relative: Relationship: Phone No. ( )

Complete Address:

Insurance: Who referred you?

Family Physician:

Insurance: Please allow us to make a copy of your insurance card(s) and provide us with all pertinent information regarding your insurance coverage.

Primary Insurance Company: Group #

Insured's Name: ID#

Insured's Date of Birth: Relationship to Patient:

Secondary Insurance Company: Group#

Insured's Name: ID#

Insured's Date of Birth: Relationship to Patient:

I authorize this physician to release any information acquired in the course of my examination or treatment to my insurance carrier (s). I hereby authorize payment directed to my physician of the surgical and/or medical benefits, if any, otherwise payable to me for services. **I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE OR FEE NOT COVERED AND OR ANY COST OF COLLECTION. Should it be necessary to enforce the provisions of this agreement through an attorney or any legal proceedings, the undersigned promises to pay all cost of collection, including reasonable attorney's fee and all court costs.**

SIGNED: DATE:

Revised 3/1/2014