



PATIENT INFORMATION

Please Print (ALL INFORMATION MUST BE COMPLETED)

Date: _____

Patient's Name _____ Referred By _____
 Last First MI
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 SS# _____ - _____ - _____ D.O.B _____ / _____ / _____ Sex: M F
 Married _____ Divorced _____ Separated _____ Widowed _____ Single _____
 Patient's Occupation _____ Employer _____
 Employer's Address _____ Employer's Phone # _____
 Emergency Contact _____ Phone # _____
 Relationship to Patient _____

PRIMARY INSURANCE TO FILE

Insured's Name: (Name EXACTLY as it appears on Insurance Card)	Relationship to Patient:
Policy # :	Insured's DOB:
Group # :	Insured's Social Security # or I.D.# :
Insured's Employer	Employer's Phone
insured's Address:	Phone
City:	State Zip

SECONDARY INSURANCE TO FILE

Insured's Name: (Name EXACTLY as it appears on Insurance Card)	Relationship to Patient:
Policy # :	Insured's DOB:
Group # :	Insured's Social Security # or I.D.# :
insured's Employer:	Employer's Phone
insured's Address:	Phone
City:	State Zip

Payment is required for ALL services at the time they are rendered. In the event of financial hardship, our office will attempt to negotiate a payment plan or file the appropriate insurance when hospitalization or major procedures are required. However, before such claims are filed, coverage will be pre-certified, and you will be asked to pay any unmet deductible, non-covered services and copayments. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize all physicians, medical professionals, hospitals and other medical care institutions, insurers, prepaid health plans, employers, group policy holders, contract holders, and benefit plan administrators to provide insurer with information concerning medical care, advice, treatment or supplies provided to the patient.

Signature _____

Date _____