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:		Relationship to Patient:
(Name EXACTLY as it appears on Insurance Card)		Insured's DOB:
Policy # :		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:		Relationship to Patient:
(Name EXACTLY as it appears on Insurance Card)		Insured's DOB:
Policy # :		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**_____