PATIENT INFORMATION

Thank you for choosing our office! Please print. All information is kept confidential.

Patient (first, MI, last) _____ Date _____

Address_____ Apt #_____ City_____ St_____ Zip_____

Home phone_____ Cell phone_____ Employer_____ Business phone _____

Birth date _____ ☐Male ☐Female ☐Single ☐Married ☐Widowed

Social Security Number_____ ReferringPhysician_____

Emergency contact _____ Phone _____

BILLING INFORMATION-Do not complete if patient is responsible party.

Responsible party _____ Relationship to patient _____

Address_____ City_____ St_____ Zip_____

Home phone _____ Cell Phone_____ Employer_____ Business phone _____

Birth date _____ Social Security Number_____

PRIMARY INSURANCE

Insurance subscriber (first, MI, last) _____ Relationship to patient _____

Address_____ City_____ St_____ Zip_____

Home phone _____ Business phone _____ Cell phone _____

Birth date _____ Social Security Number _____

Employer _____

Insurance Company _____

SECONDARY/SUPPLEMENTARY INSURANCE

Insurance subscriber (first, MI, last) _____ Relationship to patient _____

Address_____ City_____ St_____ Zip_____

Home phone _____ Business phone _____ Cell phone _____

Birth date _____ Social Security Number _____

Employer _____

Insurance Company _____

By signing below, I authorize the release of the patient's healthcare information for submitting claims for health insurance benefits; and payment of insurance benefits to the healthcare provider. I take full responsibility for payment of uncovered procedures and balance of account after insurance payments.

Signature of patient or parent of minor_____ Date_____

Pharmacy preference_____

Whenever possible, prescriptions may be sent electronically so please check with your pharmacy.