

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 _____

Cell phone(preferred) _____ Home Phone _____ Business phone _____

Birth date _____ Male Female Single Married Widowed

Email _____ Employer _____

Social Security Number _____ Preferred method of contact: (circle one or more) Text Email Phone

Emergency contact _____ Phone _____

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

Responsible party _____ Relationship to patient _____

Address _____ City _____ St _____ Zip _____

Cell Phone(preferred) _____ Home Phone _____ Business phone _____

Employer _____ Birth date _____ Social Security Number _____

PRIMARY INSURANCE

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

Address _____ City _____ St _____ Zip _____

Cell phone(preferred) _____ Home phone _____ Business phone _____

Birth date _____ Social Security Number _____

Employer _____

Insurance Company _____

SECONDARY/SUPPLEMENTARY INSURANCE(If applicable)

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

Address _____ City _____ St _____ Zip _____

Cell phone(preferred) _____ Home phone _____ Business 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 _____ Prescriptions will be sent electronically, check with your pharmacy after your visit.