CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ____/____/____ AGE _____ Male ☐ Female ☐

ADDRESS _____ APT # _____ SSN _____-_____-_____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____)_____

ALTERNATE PHONE (_____)_____ E-MAIL ADDRESS _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP_____

WORK PHONE (_____)_____ EXT. _____ DATE SYMPTOMS BEGAN:_____/_____/_____

PRIMARY CARE PHYSICIAN _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____ PHONE _____

CLAIM INFORMATION:

TYPE OF CLAIM: ☐ GROUP HEALTH INSURANCE ☐ CASH ☐ MEDICARE

I WILL BE PAYING TODAY BY: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ OTHER

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? ☐ SELF ☐ SPOUSE ☐ OTHER ☐ CHILD SPOUSE: _____

INSURED'S EMPLOYER: If different from above, _____ ☐ SAME AS ABOVE

INSURED'S SSN: _____-_____-_____ ☐ SAME AS ABOVE INSURED'S DOB _____/_____/_____ ☐ SAME AS ABOVE

PRIMARY INSURANCE CO. _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE # (_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE CO. _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE # (_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____