Confidential Patient Information

PATIENT INFORMATION

FULL NAME ____________________ DATE OF BIRTH ____/____/_____ AGE ____ M ___ F ___

ADDRESS ____________________ APT # ____________ SSN ______ - _____ - _________

CITY ______________ STATE _________ ZIP CODE _______________ HOME PHONE ______________

BEST # TO CALL OR LEAVE MESSAGE ____________________ CELL PHONE ______________

EMPLOYER'S NAME ____________________ OCCUPATION ______________

WORK ADDRESS ______________ WORK PHONE ______________ IS IT OK TO CALL WORK? YES ___ NO ___

PHARMACY YOU USE ____________________ PHARMACY PHONE NUMBER ______________

MARITAL STATUS: SINGLE ____ MARRIED ____ WIDOWED ____

EMERGENCY CONTACT ____________________ PHONE ______________

CLAIM INFORMATION

IS YOUR CONDITION DUE TO: AN AUTO ACCIDENT _____ PERSONAL INJURY _____ WORK INJURY _____

TYPE OF CLAIM: CASH _____ HEALTH INSURANCE _____ MEDICARE _____

INSURANCE INFORMATION

RELATIONSHIP TO INSURED? SELF _____ SPOUSE _____ OTHER _____ CHILD _____ SPOUSE'S NAME ______________

INSURED DATE OF BIRTH ____/____/_____ INSURED SSN _______ - _____ - _________

PRIMARY INSURANCE COMPANY ____________________

ADDRESS ____________________ PHONE NUMBER ______________

POLICY NUMBER ____________________ GROUP NUMBER ______________

SECONDARY INSURANCE ____________________

ADDRESS ____________________ PHONE NUMBER ______________

POLICY NUMBER ____________________ GROUP NUMBER ______________

AUTHORIZATIONS: PLEASE READ CAREFULLY

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 SIGNATURE ____________________ DATE ______________

GUARDIAN SIGNATURE ____________________ DATE ______________