

PATIENT INFORMATION SHEET

(Please print clearly and fill out completely.)

Date: ___/___/___

E-mail address: _____

Name of Patient: _____

Last

First

Middle

Mailing Address: _____

Street

Apt#

City

State

Zip

Home Telephone No. (____) ____ - ____ Cell No. (____) ____ - ____ Occupation: _____

Social Security No. ____ - ____ - ____ Birth Date: ___/___/___ Age: _____ Sex: _____

Employer's Name: _____ Phone No. (____) ____ - ____

Employer's Address: _____

Wife, Husband, or Parent Name: _____ S.S. of Spouse ____ - ____ - ____

Employed at: _____ Phone No. (____) ____ - ____ DOB: ___/___/___

Address: _____

Nearest Relative: _____ Relationship: _____ Phone No. (____) ____ - ____

Complete Address: _____

Insurance: _____ Who referred you? _____

Family Physician: _____

I authorize this physician to release any information acquired in the course of my examination or treatment to my insurance carrier (s). I hereby authorize payment directed to my physician of the surgical and/or medical benefits, if any, otherwise payable to me for services. **I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE OR FEE NOT COVERED AND OR ANY COST OF COLLECTION.**

SIGNED: _____ DATE: ___/___/___

Insurance: Please allow us to make a copy of your insurance card(s) and provide us with all pertinent information regarding your insurance coverage.

Primary Insurance Company: _____ Group # _____

Insured's Name: _____ ID # _____

Insured's Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ Group # _____

Insured's Name: _____ ID # _____

Insured's Date of Birth: _____ Relationship to Patient: _____