Patient Information

Thank you for choosing our office! In order to better serve you properly, we need the following information. Please print neatly and fill it out completely! All information will be confidential.

Date _____ Patient Name _____ S.S# _____
Sex _____ Birthdate _____ Minor _ Married _ Divorced _ Separated _ Widowed _ Single_
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Alternate Number _____
Primary Care Physician: **_____** ***Phone:*** **_____**
Fax: **_____**
Ethnicity ____ Non-Hispanic ____Hispanic Preferred Language: _____ Race: _____
E-mail address _____
Employer _____ Work Phone Number _____
Employer Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Phone Number _____
Who may we thank for referring you? _____
If referred by Physician please provide their office phone number: _____
PHONE BOOK: Yellow Pages Dex Yellow Book **INTERNET**: Google AOL Yahoo **OTHER**: Friend/Relative Office Sign
OTHER (please list): _____

Responsible Party (Parent or Guardian)

Name of person responsible for this account _____ Relationship _____
Birthdate _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Alternate Number _____
Employer _____ Work Phone Number _____
Employer Address _____ City _____ State _____ Zip _____
E-mail address _____

Insurance Information (Policy Holder)

Name of Insured _____ Relation to patient _____
Birthdate _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Alternate Number _____
Employer _____ Work Phone Number _____
Employer Address _____ City _____ State _____ Zip _____
Name of Insurance _____ HMO PPO EPO Other _____

Do you have an additional insurance? Yes __ No __ If yes, Complete the following:

Name of Insured _____ Relation to patient _____
Birthdate _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Alternate Number _____
Employer _____ Work Phone Number _____
Employer Address _____ City _____ State _____ Zip _____
Name of Insurance _____ HMO PPO EPO Other _____

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided to me (or my child's) referring physician, as well as the insurance co for the purpose of evaluating and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to the doctor. **I understand that my insurance company is being billed as a courtesy to me. Any benefits not paid by my insurance company will be my responsibility to pay.** If unable to keep an appointment kindly give 24 hour notice or a $50 fee will be charged.

x_____ **_____**
SIGNATURE OF PATIENT (PARENT IF A MINOR) **DATE**