

PATIENT INFORMATION

(Please Print)

Today's Date ____/____/____

Name _____ E-mail: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/____ Age _____ Sex _____ Employer _____ SS# _____

RESPONSIBLE PARTY (if different from patient)

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ SS# _____

Date of Birth ____/____/____ Sex _____ Employer _____

INSURANCE INFORMATION (Please present insurance card at time of check in)**Primary** Insurance Name _____

Name of Insured _____

Date of Birth of Insured ____/____/____

Insured's SS# _____

Group # _____

Relationship of patient to the Insured _____

Secondary Insurance Name _____

Name of Insured _____

Date of Birth of Insured ____/____/____

Insured's SS# _____

Group # _____

Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by _____

Primary Care Physician _____

Do we have your permission to:

Leave a message on your answering machine at home? YES NOLeave a message at your place of employment? YES NODiscuss your medical condition or financial information with any member of your household? YES NO

If yes, whom: _____ Relationship: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature/Parent or Guardian if Minor _____ Date ____/____/____

I understand and agree that, (regardless of my insurance status) I AM ULTIMATELY RESPONSIBLE for the balance on my account for any professional services rendered. I have read and filled out all of the health questions and insurance information to the best of my ability. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of insurance status as indicated in the above information.

MONTHLY SERVICE CHARGES OF 1.5% (TIME/PRICE DIFFERENTIAL ARE ASSESSED ON UNPAID BALANCES). UNLESS CANCELLED 24 HOURS IN ADVANCE, \$60.00 WILL BE CHARGED FOR MISSED APPOINTMENTS. ALSO FOR NO SHOW SURGERY APPOINTMENTS \$150.00 PER EACH 30 MINUTES OF MISSED APPOINTMENT TIME WILL BE CHARGED.

SIGNATURE _____

DATE _____

SIGNATURE OF PARENT OF GUARDIAN (IF MINOR) _____

DATE _____