PATIENT INFORMATION

Full Legal Name _____ Name you go by_____
First Middle Last
Address_____
Street City State Zip
Primary phone _____Secondary Phone_____ Work Phone _____

Date of Birth _____/_____/_____ Age_____ Marital Status _____ Sex: M_____ F_____

Employer_____ Social Security #_____

In Case of Emergency, who should be notified?_____ Phone:_____

Did your doctor refer you? _____Yes _____No

Name of referring doctor _____ Phone: _____

Referring doctor's address _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Relation to patient_____
First Last
Address (if different from patient)_____

Home phone _____ Work phone number_____ SS#_____ Date of birth____/____/____

INSURANCE INFORMATION (WE MUST HAVE COPY OF YOUR CARDS)

Primary Insurance _____

Name of insured _____

Date of birth ____/____/____ Group _____

Policy Number _____

Relation to patient_____

Secondary Insurance _____

Name of Insured_____

Date of birth ___/___/___ Group _____

Policy number _____

Relation to patient ____ _____

It is your responsibility to verify and maintain coordination of benefits if you are covered by more than one insurance policy.

PAYMENT POLICY

If we participate with a commercial insurance plan under which you are covered, we will bill the carrier charges for all covered, medically necessary services rendered. Your signature authorizes payment of medical benefits to the physician when an assigned claim is filed. You will be responsible at the time of service for deductibles, copayment, and also charges for any non-covered, or cosmetic services.

If we do not participate with your insurance or you do not have insurance, you will be responsible for payment in full at time of service. We accept Visa, MasterCard, Discover, personal checks, and cash.

Your signature below signifies that your understand our financial policy and your responsibility regarding charges incurred in our office. It also authorizes us to release any medical information necessary to process insurance claims, insurance applications and prescriptions.

_____ _____
Signature of patient or legal guardian Date