PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____

STATE/ZIP _____ SOC. SEC. # _____

EMPLOYER _____ EMP. ADDRESS _____

STATE/ZIP _____ TELEPHONE _____

HOME PHONE _____ OCCUPATION _____

WORK PHONE _____ EMAIL ADDRESS _____

2ND PHONE _____

Circle One *CELL* *MESSAGE* *OTHER*

BIRTHDATE _____ AGE _____ SEX M / F

MARITAL STATUS _____

PRIMARY CARE _____

REFERRING DR. _____

REFERRAL SOURCE (CHECK ONE)

PHONE BOOK _____ *DOCTOR* _____

INSURANCE _____ *FRIEND* _____

NEWSPAPER _____ *OTHER* _____

SPECIFY:

PATIENT BILLING INFORMATION

IF DIFFERENT THAN ABOVE

FIRST NAME_____LAST NAME_____

ADDRESS_____ CITY_____STATE _____ZIP_____

DATE OF BIRTH _____ SOC. SEC. # _____RELATIONSHIP TO PATIENT_____

INSURANCE BILLING INFORMATION

INSURED'S FIRST NAME_____LAST NAME _____

INSURED'S ADDRESS_____ CITY _____STATE _____ZIP_____

INSURED'S DATE OF BIRTH _____ INSURED'S S.S. # _____RELATIONSHIP TO PATIENT_____

I authorize the release of medical information necessary to process claims or obtain treatment. I authorize payment be made directly to the physician/clinic for services or supplies provided. **I understand I am responsible for charges not paid by my insurance**. I understand I am responsible for obtaining referrals for services/supplies need and I will be charged for those supplies/services received without a referral in place.

Signature _____ Date _____