# Patient Information

Patient's Name:____________________________________________ Date of Birth:______________________

Physical Address: _________________________________Mailing address: ______________________________

City: _________________________________State: _____________ Zip: _______________________

Home Phone: ______________________Cell: __________________________Work:____________________
May we leave a message on ☐ Voice Mail ☐ Answering Machine ☐ With specified person/s: _________________

---

☐Male ☐ Female ☐ Single ☐ Married ☐ Divorced Full-Time Student? ☐ Yes ☐ No

Patient's Social Security #:__________________________☐Patient ☐ Parents Driver license # :______________

**Emergency Contact**

**Name:** ________________________________ **Relationship:**___________________ **Phone #**_______________

*Referred by: (please circle) Newspaper Friend Relative Pharmacy Other

Name:______________________________________________________________________________________

# Responsible Party

Responsible Party's Name: _____________________________________Phone:_________________________

Address: ________________________________________________________________________________

Employer Name: _____________________________________ Employer phone #:_________________________

# Insurance Information

**Primary Insurance**

Insurance Company: _________________________

ID#______________________________________

Group#___________________________________

Policy Holder:______________________________

Policy Holder SS#___________________________

Policy Holder DOB: _________________________

**Secondary Insurance**

Insurance Company: _________________________

ID#______________________________________

Group#___________________________________

Policy Holder:______________________________

Policy Holder SS#___________________________

Policy Holder DOB: _________________________

**(continue to pg 2)**

## Authorization For Release of Information

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent Insurance company (s) or third party carriers and request that payment is made directly to the billing entity, I also request that payment of benefits from my secondary Insurance carrier be paid to the billing entity until otherwise notified.

**Sign:**________________________________________________________________________

## Office Policies

1. I understand that I am financially responsible for any balance not covered by my insurance carrier.
2. I understand that co-payments are due at the time of service.
3. I understand that a copy of my insurance card must be shown at each visit.
4. I understand that I am responsible for providing a referral from my (PCP) Primary Care Physician, should my insurance require one, and that if one is not received, my appointment will be cancelled.

**Sign:**________________________________________________________________________