Patient Information Form

Date: ______________________________

PATIENT'S INF0RMATION:

Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip code: __________________

Phone numbers: Home: ______________________ Work: ______________________

Mobile: ______________________

Email address: ______________________________

Sex: ________ Date of Birth: __________________ Age: ______ Marital Status: __________

RESPONSIBLE PARTY (statements will be sent to):

Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip code: __________________

Phone numbers: Home: ______________________ Work: ______________________

Mobile: ______________________

Email address: ______________________________

Sex: ________ Date of Birth: __________________ Age: ______ Marital Status: __________

Relationship to patient: ______________________________

PRIMARY INSURANCE INFORMATION:

Insurance Company: ______________________________ Phone #: ____________________

Subscriber's Name: ______________________________ SS#: ____________________________

Employer: ____________________________________ Group #: __________________________

Date of Birth: ________________________ Subscriber's ID: ______________________________

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.

AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

SIGNED: ____ DATE: __________________

(patient, or parent if patient is a minor)