PATIENT INFORMATION

Patient's name: ____
(last, first, middle)

Date of Birth: ____________________ Sex: __________

Social Security Number: ______________________

Marital Status: Single Married Divorced Widowed

Address: ____

City: ______________ State: __________ Zip: ______________

Phone: _____________ Relationship to Insured: ____________________

EMPLOYER

Name: __________________ Work Number: __________________

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INSURANCE (Please present card(s) to the receptionist.

1st Insurance Name: ______________ ID# ______________ Policy Holder: ____________

2nd Insurance Name: ______________ ID# ______________ Policy Holder: ____________

3rd Insurance Name: ______________ ID# ______________ Policy Holder: ____________

IN CASE OF AN EMERGENCY CONTACT:

Name: __________________ Phone: ____________ Relationship: ______________

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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedure, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patients records.

This assignment will remain in effect until revoked by you in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: ____________________________________ **Date:** __________

Signed: ____________________________________ **Date:** __________