PATIENT INFORMATION ❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Name _____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Social Security #_____ Sex: ❑ Male ❑ Female

ADDRESS:

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____
Last *First* *M.I.*

Address: _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Date of Birth: ____/____/____ SS#_____ Sex: ❑ Male ❑ Female

INSURANCE COVERAGE - <u>PRIMARY:</u>

Insurance Co. Name: _____ Phone: ( )_____ Ext: _____

Address of Claim Center: _____

_____
City *State* *Zip Code*

Name Policy Holder (Insured): _____ Date of Birth: ____/____/____

Policy #: _____ Group Name or #: _____

Policy Type: ❑ HMO ❑ PPO

Employer Name: _____

Employer Address: _____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other _____
(Identify)

INSURANCE COVERAGE - <u>SECONDARY:</u>

Insurance Co. Name: _____ Phone: ( )_____ Ext: _____

Address of Claim Center: _____

_____
City *State* *Zip Code*

Name Policy Holder (Insured): _____ Date of Birth: ____/____/____

Policy #: _____ Group Name or #: _____

Policy Type: ❑ HMO ❑ PPO

Employer Name: _____

Employer Address: _____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other _____
(Identify)

Referred by: _____

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)

REFERRAL INFORMATION
PATIENT FINANCIAL POLICY AND
SIGNATURE ON FILE

Patient Name: _____ Today's Date: _____

Other family members that are patients: _____

Referred by: _____ Primary Care Physician _____

Pharmacy of choice _____ Phone ( )_____

In case of Emergency, who should be notified?_____ Phone ( ) _____

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____

PAYMENT POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services, at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitilization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date _____