PATIENT INFORMATION

PATIENT NAME:____ TITLE (MR/MRS/MS):____________________
PATIENT NICKNAME:______________________________ SOCIAL SECURITY #:__________________________
PATIENT ADDRESS:____
CITY:___________________________________ STATE:_____________________ ZIP:____________________
HOME PHONE:_______________________________ WORK PHONE:______________________________
BIRTHDATE:__________________ AGE:_________ SEX: ☐M ☐F MARITAL STATUS (S/M/D/W):_________
RELATION TO RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER __________________________
DRIVERS LIC #:_________________________ STATE OF ISSUE:___ _______ REFERRED BY:_________________
PATIENT EMPLOYER:_______________________________ OCCUPATION:____________________________
EMPLOYER ADDRESS:____________________________ CITY:______________ STATE:_____ZIP:_____________
IF STUDENT, SCHOOL ATTENDING:___________________________ FULL/PART TIME:____________________
SPOUSE'S NAME:______________________________ SPOUSE'S WORK PHONE:________________________
IN CASE OF EMERGENCY:_____________________ RELATIONSHIP:___________ PHONE:_________________
ADDRESS:____
FAMILY PHYSICIAN:_____________________________________ PHONE:______________________________

FINANCIAL RESPONSIBILITY PARTY (GUARANTOR)

GUARANTOR NAME:___________________________ (MR/MRS/MS):_________ BIRTHDATE:______________
GUARANTOR ADDRESS:____
CITY:______________________________ STATE:____________________ ZIP:__________________________
HOME PHONE:________________________ WORK PHONE:____________________ EXT. #:______________
GUARANTOR EMPLOYER:______________________________ OCCUPATION:__________________________
EMPLOYER ADDRESS:_____________________________ CITY:_______________ STATE:____ ZIP:___________
DRIVERS LIC #:______________________________ SOCIAL SECURITY #:____________________________
SPOUSE'S NAME:______________________________ SPOUSE'S WORK PHONE:_________________________
RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE CO:___________________________ GROUP NO.:______________________________
SUBSCRIBER'S NAME:__________________________ SUBSCRIBER'S ID #:______________________________
SUBSCRIBER'S RELATION TO PATIENT: ☐SELF ☐SPOUSE ☐CHILD ☐ OTHER _______________________
EFFECTIVE DATE:____ ___________________________
SECONDARY INSURANCE CO.:__________________________ GROUP NO.#____________________________
SUBSCRIBER'S NAME:____________________________ SUBSCRIBER'S ID #:____________________________
SUBSCRIBER'S RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐CHILD ☐ OTHER _______________________
EFFECTIVE DATE:____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference, and if the nature of the disability be such that is it not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

SIGNED:____ DATE:________________________________

I understand that all appointments must be cancelled at least 24 hours in advance, or I may be charged a late cancellation or no-show charge. Checks returned uncashed by the bank for any reason will be charged a "Returned Check Charge" of $10.00.

SIGNED:____ DATE:________________________________

ACCT. NO.:____ DX:__________________________________