

PATIENT INFORMATION

Today's Date: _____ Medication Allergies: _____

Patient's Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Work#: _____ Cell#: _____

E-mail Address: _____ Religion: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Patient's Employer: _____ Occupation: _____

Spouse's Name: _____ SS#: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____ Work#: _____

Emergency Contact: _____ Phone#: _____

Family Physician: _____ Referred By: _____

IF PATIENT IS A MINOR:

Mother's Name: _____ Date of Birth: _____ SS#: _____

Mother's Employer: _____ Work#: _____ Home#: _____

Father's Name: _____ Date of Birth: _____ SS#: _____

Father's Employer: _____ Work#: _____ Home#: _____

Party Responsible For Bill: _____

Address (if different from patient): _____

PLEASE READ THE FOLLOWING AUTHORIZATION & SIGN AT THE BOTTOM:

I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, or my private insurance carrier any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize the doctor to bill all services and allow my insurance carrier to issue indemnity payments directly to the physician. I understand that any services not covered by insurance are the responsibility of the responsible party.

I have received a copy of the physicians practice **PRIVACY POLICY**

Signature of Patient

Date

Signature of Parent (if minor)

Signature of Responsibility Party

I prefer to be contacted at work _____ /home _____ /cell _____ (check one)