Patient Information for Medical Records (please print)

Social Security # _____

Name _____ **Driver's License #** _____

Last First Middle Initial **Birthdate** ____/____/____

Age _____

Home Address _____ **City** _____ **State** ____ **Zip** _____

Home Phone (**)** _____ **Work Phone (** **)** _____ **Cell** _____

Email Address _____

Marital Status (please circle): Married Single Divorced Separated Widow Minor

Employed By _____ **Occupation** _____

Work Address _____ **City** _____ **State** ____ **Zip** _____

Spouse/Parent _____ **Occupation** _____

Last First Middle Initial

Employed By _____ **Work Phone (** **)** _____

Work Address _____ **City** _____ **State** ____ **Zip** _____

Who to notify in an emergency _____ **Phone (** **)** _____

Who referred you to this office? _____

Medical Insurance Information

How do you intend to pay? (Please circle) Cash Check Credit Card Insurance Medicare

Name of insurance company _____ **ID#** _____

Group # _____

Address _____ **City** _____ **State** _____ **Zip** _____

If someone other than patient is responsible for payment, Please complete this section

Name of responsible party _____

Address _____ **City** _____ **State** _____ **Zip** _____

Relationship to Patient _____ Social Security # _____

Employed By _____ Work Phone _____ Cell Phone _____

Please sign and return to front desk

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO _____ ALL SURGICAL AND/OR MEDCIAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEARBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

Date _____ Signed _____