PATIENT INFORMATION

Rev. 01/19

Date: _____

Name: _____ M ☐ F ☐ Status: _____
Last First M. Single, Married, Divorced, Widowed, Partnered

Date of Birth: _____ SSN: _____Driver's License No: _____

Address: _____
Street City State Zip

Telephone: _____ _____ _____
Primary H ☐ W ☐ C ☐ Alt. H ☐ W ☐ C ☐ Alt. 2 H ☐ W ☐ C ☐

Do you authorize our office to leave a voice message regarding your personal and/or health information? ☐ Y ☐ N

Spouse Name: _____ SS#: _____

Date of Birth: _____ Primary Phone: _____Alt Phone: _____

Do you authorize your spouse to access your personal and/or health information? ☐ Y ☐ N

Do you authorize any other person to have access to your personal and/or health information?

NO ____YES ____ Name/Relationship _____Phone:_____

Emergency Contact: _____Phone: _____
Name Relationship

Please list the name and phone number of any physician that has treated to you in the past six months:
Name: _____Specialty:_____Phone:_____
Name: _____Specialty:_____Phone:_____
Name: _____Specialty:_____Phone:_____

Primary Insurance Co: _____ Insurance Phone: _____

Subscriber's Name: _____Date of Birth: _____ SSN:_____

ID No: _____ Group No:_____ Employer Name: _____

Secondary Insurance Co: _____Insurance Phone: _____

Subscriber's Name: _____Date of Birth: _____SSN:_____

ID No: _____ Group No: _____ Employer Name: _____

***BY SIGNING BELOW I AGREE TO THE FOLLOWING*:**

1. **THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND ACCURATE. PROVIDING FALSE INFORMATION CAN RESULT IN TERMINATION OF SERVICES.**
2. **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS A CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO THE PARTY THAT ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES.**
3. **I AM RESPONSIBLE FOR PAYMENT IN FULL IF MY INSURANCE COMPANY DENIES PAYMENT FOR SERVICES FOR ANY REASON.**
4. **IT IS MY RESPONSIBILITY TO CANCEL ANY SCHEDULED APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A CHARGE EQUAL TO THE AMOUNT OF THAT APPOINTMENT.**

Patient's or authorized person's signature Date

Printed name and relationship of authorized person