Welcome To Our Office

Please Print

1 PATIENT INFORMATION

Date ______________ Home Phone ( ) ____________ E-mail ______________________________

Last Name ____________________ First Name __________________ Middle Initial _____ Sex ❑ M ❑ F

Street ________________________ City _________________________ State ____ Zip _______________

Social Security # ________________ Driver's License # ______________ Age _____ Date of Birth ___/___/___

Marital Status __________________ Children? ____________________ Ages _________________________

Employer ____ Phone ( ) ___________Ext.____

Street ________________________ City ________________________ State _____ Zip _______________

Occupation ____________________ May we call you at work? ❑ Y ❑ N Work Hours __________________

SPOUSE/DOMESTIC PARTNER INFORMATION (If appropriate)

Home Phone ( ) _____________

Last Name ____________________ First Name __________________ Middle Initial _____ Sex ❑ M ❑ F

Street ________________________ City ________________________ State _____ Zip _______________

Social Security # ________________ Driver's License # ______________ Age _____ Date of Birth ___/___/___

Employer ____ Phone ( ) ___________Ext.____

Street ________________________ City ________________________ State _____ Zip _______________

FINANCIALLY RESPONSIBLE PARTY (If different from patient)

Home Phone ( ) _____________

Last Name ____________________ First Name __________________ Middle Initial _____ Sex ❑ M ❑ F

Street ________________________ City ________________________ State _____ Zip _______________

Social Security # ________________ Driver's License # ______________ Age _____ Date of Birth ___/___/___

Employer ____ Phone ( ) ___________Ext.____

Street ________________________ City ________________________ State _____ Zip _______________

Occupation ____________________ May we call you at work? ❑ Y ❑ N Work Hours __________________

INSURANCE INFORMATION (If no card is available to copy)

Primary Insurer _____________________ Phone ( ) ______________ Group #____________________

Street(PO Box) ________________________ City ____________________ State ____ Zip _________________

Insured's name ______________________ Insured's ID # ______________________

Secondary Insurer ___________________ Phone ( ) ______________ Group #____________________

Street(PO Box) ________________________ City ____________________ State ____ Zip _________________

Insured's name ______________________ Insured's ID # ______________________

IN CASE OF AN EMERGENCY

Who should be notified? ______________________ Relationship _____________ Phone ( ) _____________

Who may we thank for referring you? ____

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. ________________________________ ____________

Signature Required Date

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6/13/01