Patient Information **(Please Print)** **Today's Date**_____/_____/_____

Name_____
Last First M.I.

Address_____
City State Zip

Home Phone_____ Cell_____ SSN_____
Area Code

Work Phone _____ Email_____

Date of Birth____/____/____ Age _____ Sex _____ Marital Status _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name_____
Last First M.I.

Address_____
City State Zip-

Home Phone_____ Work _____ SSN_____

Date of Birth____/____/____ Age _____ Sex _____ Marital Status _____

INSURANCE INFORMATION (Please fill out completely and present card to front desk)

Primary Insurance Name	**Secondary** Insurance Name
Ins. Address	Ins. Address
Name of Subscriber	Name of Subscriber
Subscriber SSN	Subscriber SSN
Subscriber Date of Birth	Subscriber Date of Birth
Relation to Patient	Relation to Patient
Insurance ID #	Insurance ID #
Group #	Group #
Employer Name	Employer Name
Employer Address	Employer Address

Pharmacy: _____ **Location:** _____

Emergency Contact:_____ **Relation:** _____ **Phone:** _____

Referred by:_____**Primary Care Physician:**_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications & prescriptions. I also authorize payment of medical benefits to the physician.

****Patient or Responsible Party Signature**_____ **Date** _____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments & deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

****Patient or Responsible Party Signature**_____ **Date:** _____/____/_____