CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

DATE__/__/__

PATIENT INFORMATION:

FULL NAME_____DATE OF BIRTH__/__/____ AGE_____ Male ☐ Female ☐

ADDRESS_____ APT#_____ SSN _____-____-_____

CITY_____ STATE_____ ZIP CODE_____ HOME PHONE (___) ____-_____

CELL PHONE : (____) ____-_____ E-MAIL ADDRESS_____

EMPLOYER'S NAME_____ OCCUPATION _____

WORK PHONE # (____)_ ___-_____ EXT._____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: _____ PHONE #: (____) ____-_____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any um I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature:_____ Date: _____

Guardian Signature: _____ Date: _____