

Patient Information Sheet

Welcome to our Office...

Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Form with fields for Social Security#, First Name, Last Name, Middle Initial, Date of Birth, Age, Gender, Marital Status, Street Address, City, State, Zip, Employer Name, Home Phone, Emergency Contact, Work Phone, Emergency Telephone#, Cell Phone, Primary Care Physician, E-mail, Referring Doctor.

Patient's Insurance Information

Form with two columns: Primary Insurance Company Information and Secondary Insurance Company Information. Fields include Insurance's Name, Policy ID, and Group#.

Form with two columns: Policy Holder Information. Fields include First Name, Last Name, Address, City, State, Zip, Policy Holders SS#, Policy Holders Date of Birth, and Gender.

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is a courtesy that the doctor accepts my insurance for payment and that if for any reason my insurance does not cover services rendered, including referrals, I am responsible for payment. All balances not paid in full within 30 days are subject to a \$25 charge. After 60 days the account will be placed in collection and you will be responsible for all collection fees incurred.

By signing below, I acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy and agree to comply with all of its terms.

Today's Date: _____ Patient's Signature: _____