PATIENT INFORMATION SHEET

PATIENT INFORMATION

1. (2) Name:_____ (3) Date of Birth:_____

2. (5) Address (Number & Street):_____ Apt.#_____

City:_____ State:_____ Zip Code:_____

3. Home Phone:_____ Work Phone:_____

4. (10) Is patient's condition related to: ...employment? NO____ YES____
...accident? NO____ YES____ If yes, Auto_____ Other_____

5. (8) Marital Status: Single_____ Married_____ Other_____ _____

6. (8) Employment: Employed_____ Full Time Student_____ Part Time Student_____

INSURANCE INFORMATION

7. (4) Name of Insured:_____ (1a) Insured Social Security Number:_____

8. (7) Address (Number & Street):_____ Apt.#_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____

9. (6) Relationship of patient to insured: Self_____ Spouse_____ Child_____ Other_____

10. (11a) Insured's Date of Birth:_____ Male_____ Female_____

11. (11b) Insured's Employer's Name or School Name:_____

12. (1) Insurance Company:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Phone Number:_____

13. (11) Insured's Policy #:_____ Insured's Group #:_____

14. (11c) Insurance Plan or Program Name:_____

15. Have you met your deductible?: NO_____ YES_____
Do you have a copayment for office visits?: NO_____ YES_____, How much? $_____

16. (11d) Are you covered by another Health Benefit Plan?: NO_____ YES_____ IF YES, complete questions below:

(9) Insured's Name on additional insurance Coverage:_____

(9a) Other Insured's Date of Birth:_____ Male_____ Female_____

(9c) Employer's Name or School Name:_____ (9d) Insurance Plan or Program Name:_____

ALL PATIENTS TO READ AND SIGN: I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIM TO INSURANCE COMPANY(ies) and/or PHYSICIAN ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO THE HEALTH CARE PROVIDER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE. I PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I ALSO UNDERSTAND THAT APPOINTMENTS CANCELLED WITHOUT A 24 HOUR NOTICE WILL BE ASSESSED A "CANCELLATION FEE" WHIC WOULD APPEAR ON MONTHLY PATIENT STATEMENTS AND IS NOT BILLABLE TO INSURANCE COMPANIES.

Patient's Signature _____ Date _____ Insured's Signature _____ Date _____

OFFICE USE ONLY Referring Physician:_____ Diagnosis:_____

Comments:_____