Patient Information

Please print all information in the spaces provided. Be sure to complete and sign the statement on the back of this form.

Last Name____ First Name ____________________ M.I.__________
Social Security Number _______________________ Date of Birth_________________ Email _____________________
Married_______ Single________ Other________
Address____
City ____ State __________ Zip _______________________
Cell Phone ________________________ Home Phone _______________________ Work Phone _________________
Employer Name ____
Employer Address ____
Who referred you to our office? ____

Primary Insurance

Company Name ____ Phone Number ___________________________
Billing Address ____
Name of Insured __________________________________ Relation to Patient _________________________________
Date of Birth __________________
Insured's ID Number ______________________________ Group Number ____________________________________

Secondary Insurance

Company Name ____ Phone Number ___________________________
Billing Address ____
Name of Insured __________________________________ Relation to Patient _________________________________
Insured's ID Number ______________________________ Group Number ____________________________________

Person to contact in the case of an emergency _____________________ Phone Number _______________________

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

Missed Appointment Policy
I understand that there is a $50 fee for a missed appointment with less than 24hour notice.

____ ______________________________
Signature of patient or guardian Date

OVER ⇨