PATIENT INFORMATION

Doctors Name: _____ Date _____ Patient # _____ Office Location _____

PLEASE PRINT

PATIENT'S NAME (last, first, middle)	S.S.#	MARITAL STATUS s m w d sep	SEX M F	BIRTHDATE / /	HOME PHONE ( )
STREET ADDRESS (NO PO BOX)	CITY AND STATE			ZIPCODE	BUS. PHONE ( )
EMPLOYED BY	EMPLOYER ADDRESS & ZIPCODE			DRIVERS LICENSE NO.	
NAME OF SPOUSE	SPOUSE BIRTHDATE			SPOUSE EMPLOYER NAME & PHONE	
EMERGENCY CONTACT NAME	HOME PHONE	CELL/BUS. PHONE		RELATIONSHIP TO PATIENT	
REFERRING PHYSICIAN	REF. PHYSICIAN ADDRESS			REF PHYSICIAN PHONE NO.	
PLEASE COMPLETE IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL	NAME (last, first, middle)			RELATIONSHIP	SS# (guardian if minor)
STREET ADDRESS	CITY AND STATE	ZIP CODE		HOME PHONE NO	
EMPLOYED BY	EMPLOYER ADDRESS			WORK PHONE NO	

PRIMARY INSURANCE INFORMATION

Group Health Plan Information: Please check appropriate box

☐ Patient's own coverage ☐ Coverage through spouse if no other coverage available

☐ Coverage through family member if no other coverage available

INSURANCE COMPANY	CLAIMS ADDRESS
POLICY ID NUMBER/MEDICAID NUMBER	PHONE NUMBER FOR CLAIMS/BENEFITS
GROUP ID NUMBER/GROUP PLAN NAME	INSURED'S NAME
IS THE INSURED EMPLOYED? ☐ Yes ☐ No ☐ Full time ☐ Part time ☐ Retired ☐ Student	INSURED'S BIRTHDATE
EMPLOYER NAME	PHONE # FOR PRECERTIFICATION/AUTHORIZATION

ADDITIONAL INSURANCE INFORMATION: PLEASE CHECK APPROPRIATE BOX

☐ **Secondary Insurance** ☐ **Coverage through spouse, if secondary**

☐ **Other family member insurance, if secondary** ☐ **Not applicable**

INSURED'S NAME	RELATIONSHIP TO PATIENT	INSURED'S BIRTHDAY
INSURANCE COMPANY	CLAIMS ADDRESS	
GROUP ID NUMBER	GROUP PLAN NAME	
POLICY ID NUMBER	PHONE NUMBER ( )	

ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS; HOWEVER, PATIENT / GUARANTOR IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED EXCEPT SCHEDULED PROCEDURE FEES THAT REQUIRE A DEPOSIT SEVEN (7) DAYS IN ADVANCE. **A PHOTOCOPY OF ALL INSURANCE CARDS AND DRIVERS LICENSE IS REQUIRED.**

PAYMENT METHOD: ☐CASH ☐CHECK ☐MONEY ORDER/TRAVELERS CHECK ☐CREDIT CARD(VISA/MC)

_____ _____

SIGNATURE DATE