

Patient InformationName _____
Last Name First Name MI

Address _____ City _____ St _____ Zip _____

Phone Home () _____ - _____ Work () _____ - _____ Cell () _____ - _____

Date of Birth _____ Age _____ Sex _____ Married? _____yes _____no SS# _____

E-Mail Address _____ Full Time Student _____yes _____no

Other family members who are patients _____

Pharmacy of choice _____ Phone () _____ - _____

Emergency Contact _____ Phone () _____ - _____

Do you have a referring doctor for this visit? If so who _____

Who is your primary doctor _____

Do you give our office permission to discuss medical information with any other family members?

_____yes _____no If yes, please provide their name and phone number below.

Name _____ Relationship _____

Daytime Phone () _____ - _____ Evening Phone () _____ - _____

Insurance Information**Primary Insurance:** _____

Name of Insured (Guarantor) _____ Guarantor's Date of Birth _____

Guarantor's Address (if not same as above):

Address _____ City _____ State _____ Zip _____ Phone () _____ - _____

Secondary Insurance: _____

Name of Insured (Guarantor) _____ Guarantor's Date of Birth _____

Guarantor's Address (if not same as above):

Address _____ City _____ State _____ Zip _____ Phone () _____ - _____

In order to establish optimal relations with our patients in regard to our payment policies, **PAYMENT IS EXPECTED AT TIME OF SERVICE** for "Your Part" of the charges. The Adult/Guardian who brings in a minor will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. Your signature below indicates that you understand and accept this policy. You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed. This signature also indicates that you are aware of your HIPPA rights, a copy is available upon request.