Patient Information

(Please Print)

Patient Name:____________________ Date:__________
Address:____________________
City:____________________ State:__________ Zip:__________
Phone: ( ) ______ - ______ Sex: M F Age:______ DOB:__________
SSN:__________ School:____________________

Mother/Guardian Name:____________________
SSN:__________ DOB:__________Single Married Widowed Divorced
Driver's License #:__________ E-Mail:____________________
Employer:____________________ Occupation:__________
Employer's Address:____________________
City:____________________ State:__________ Zip:__________
Daytime/Employer's Phone:( ) ______ - ______ Cell phone:( ) ______ - ______
Home Address (if different from patient):____________________
City:____________________ State:__________ Zip:__________

Father/Guardian Name:____________________
SSN:__________ DOB:__________Single Married Widowed Divorced
Driver's License #:__________ E-Mail:____________________
Employer:____________________ Occupation:__________
Employer's Address:____________________
City:____________________ State:__________ Zip:__________
Daytime/Employer's Phone:( ) ______ - ______ Cell phone:( ) ______ - ______
Home Address (if different from patient):____________________
City:____________________ State:__________ Zip:__________

Siblings Names/DOB/Sex:____________________
____

Emergency Contact Name (not living with you):____________________
Relation to patient: ____________________
Phone: ( ) ______ - ______ Alternate Phone: ( ) ______ - ______
Referring Physician:____________________ Phone: ( ) ______ - ______

Insurance Information

Primary Insurance Company:____________________
Phone: ( ) ______ - ______ Type of Insurance (circle one) HMO PPO POS Other
Primary Insured's Name: ____________________ Relationship to Patient:__________
ID#:__________ Group#: __________ Effective Date:__________

Secondary Insurance Company:____________________
Phone: ( ) ______ - ______ Type of Insurance (circle one) HMO PPO POS Other
Primary Insured's Name: ____________________ Relationship to Patient:__________
ID#:__________ Group#: __________ Effective Date:__________

The undersigned agrees that all services are rendered on a paid basis only. Our policy is to collect for services at the time they are rendered. If collection becomes necessary, the undersigned shall pay all reasonable costs. We will bill insurance for those companies that we have a contractual obligation to do so. The undersigned agrees to authorize insurance benefits to be paid directly to the physician. The undersigned is responsible for all non-covered services. The undersigned authorizes the physician to provide any information required to process claims for benefits. Parents agree to have chart notes copied and forwarded when requested by a specialist or school.

Mother/Guardian Signature:____________________ Date: __________

Father/Guardian Signature:____________________ Date: __________