PATIENT INFORMATION FORM

Today's date:______________________

Last Name: ______________________________________ First Name: ____Middle Initial: ________

Home Address: ____

City: __________________________________ State: ________ Zip: ____________Email Address: ______________________________________

Home Phone: (____) _______________________ Cellular Phone: (____) ______________________________ Social Security #: ___________________

Date of Birth: __________________________ Age: ___________ Sex: F___ M___ Marital Status: _______________________

Employer Name & Address: ____

Work Phone: (____) _____________________ Ext: ________ Fax: (____) ______________________________

Emergency Contact: ________________________________ Relationship: ______________________ Phone: (____) ______________________

Primary Care Physician: ____ Referring Physician: ____

HEALTH INSURANCE INFORMATION

Will you be using your health insurance? __Yes __No I DO NOT HAVE HEALTH INSURANCE: ______ (initial)

Primary Insurance Carrier & Address: ____

Subscriber ID: ______________________ Group Number: ___________________________ Phone number: _________________

Policy Holder: _________________________________ Date of Birth: ____________ Relationship to Patient: _______________

Secondary Insurance Carrier & Address: ____

Subscriber ID: ______________________ Group Number: ___________________________ Phone number: _________________

Policy Holder: _________________________________ Date of Birth: ____________ Relationship to Patient: _______________

Is this related to an accident? If yes complete the following: __Yes __No

AUTOMOBILE ACCIDENT/ WORKERS COMPENSATION INSURANCE INFORMATION

Date of Accident: _____________ Cause of Injury: __Auto __Work Comp __Other State Injury Occurred: ______

Insurance Carrier: ____ Med Pay Benefit Available: __________________

Policy #: ____ Claim #: ____

Name of Adjuster: ___________________________________ Adjuster's Phone #: ____

Fax #: ______________________________

Third Party Auto Insurance: __________________________ Policy #: ______________________ Phone #: __________________

Attorney Name & Address: ____

Phone number: ______________________ Fax Number: ______________________ Case Manager: _________________________

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in Full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INDURANCE OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collections, the collections fees and/or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top

Patient's Signature: ____ Date: __________________________

header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment via fax transmittal or hard copy.

Patient's Signature: ____ Date: ________________________________