Patient Information Form

Name:_____ Date:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Email:_____

Email_____

Date of Birth:_____ Age:_____ Gender: M F Height:_____ Weight:_____

Business / Employer:_____ Type of work:_____

Guardian Name_____ DOB:_____ SSN:_____

Spouse/Guardian Employer:_____ Bus. Phone:_____

Emergency Contact:_____ Phone:_____

Whom may we thank for referring you?_____

Physician:_____ Phone:_____

Financial Arrangements

Who is **FINANCIALLY RESPONSIBLE** for this bill?_____

I will be paying today by: ___CASH ___CHECK ___CREDIT CARD

Insurance Information

Type of insurance: ___Medicare ___Personal Health ___Auto ___Work Comp.

Name of insured:_____ DOB_____ SSN:_____

Name of insurance company:_____ Phone:_____

Address:_____City:_____ State:___ Zip:_____

Policy #_____ Group #_____

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time with written notice.

_____ _____

Signature of patient or person acting on patient's behalf Date

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments, or non covered services as may be required by my insurance plan.

_____ _____

Signature of patient or person acting on patient's behalf Date