

**PATIENT INFORMATION**

(No nicknames please)

**PATIENT NAME:**

LAST FIRST MIDDLE

**ADDRESS:**

**ZIP CODE:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **SEX:** FEMALE MALE

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **CHILD LIVES WITH:** MOTHER FATHER GUARDIAN

**HOME PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_

**MOM'S NAME** \_\_\_\_\_ **MOM'S DOB** \_\_\_\_\_ **MOM'S SS#** \_\_\_\_\_

**DAD'S NAME** \_\_\_\_\_ **DAD'S DOB** \_\_\_\_\_ **DAD'S SS#** \_\_\_\_\_

**MOTHER WORK PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_ **FATHER WORK PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_

**MOTHER CELL PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_ **FATHER CELL PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_

**MOTHER EMAIL ADDRESS:** \_\_\_\_\_ **FATHER EMAIL ADDRESS:** \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **ALLERGIES:** \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

**RESP. PARTY NAME:**

LAST FIRST MIDDLE

**ADDRESS:**

**RESPONSIBLE PARTY'S EMPLOYER INFORMATION:** COMPANY: \_\_\_\_\_

**CITY & STATE:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY:**

**ID#:** \_\_\_\_\_ **INSURED'S NAME:** \_\_\_\_\_

**PATIENT RELATIONSHIP TO SUBSCRIBER:** (circle one) SELF SPOUSE CHILD OTHER

**GROUP NUMBER:** \_\_\_\_\_ **COPAY AMOUNT:** \$ \_\_\_\_\_ **INSURED'S DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECONDARY INSURANCE COMPANY:** \_\_\_\_\_

**ID#:** \_\_\_\_\_ **INSURED'S NAME:** \_\_\_\_\_

**PATIENT RELATIONSHIP TO SUBSCRIBER:** (circle one) SELF SPOUSE CHILD OTHER

**GROUP NUMBER:** \_\_\_\_\_ **COPAY AMOUNT:** \$ \_\_\_\_\_ **INSURED'S DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**(OVER PLEASE)**

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.**

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**OFFICE POLICY ON PAYMENT:**

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 90 days will be charged an interest rate of 1 1/2 percent per month (18% per annum). In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company.

**INSURANCE POLICY:**

**You are responsible for all copays, coinsurance, deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original.

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

**I certify that the information I have provided is true and accurate. I have read the above and accept financial responsibility in full for this account .**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Patient, Parent, or Guardian

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**IN CASE OF EMERGENCY PLEASE CONTACT:**

NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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