PATIENT INFORMATION (CONFIDENTIAL)

Name (First) ____________________ (MI) ______ (Last) ___________________________ Date ________________
Address _________________________________ City __________________ State __________ Zip ______________
Cell Phone ______________________________ Home Phone_____________________________
E-Mail ____ Birthdate ___________________________
SS# ____
Check Appropriate Box: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated
Person to contact in case of an emergency ________________________________ Phone ____________________

RESPONSIBLE PARTY (if different than patient)

Name of Person responsible for this Account _______________________ **Relationship to Patient** ____________
Address _______________________________ City ____________________ State ____________ Zip ____________
Driver's License # ________________________ Birthdate _____________________ SS# _____________________
Employer ____ Work Phone ___________________________
Is this person currently a patient in our office? [ ] Yes [ ] No

INSURANCE INFORMATION

As a courtesy to our patients, we will process insurance claims for services rendered. HOWEVER, charges incurred for services rendered are always the responsibility of the patient or responsible party. You are responsible for knowing what coverage you have under your plan and exactly what benefit coverages are included. Any dispute arising over insurance coverage, non-allowable expenses, etc, are between you and your insurance carrier and should under no circumstances interfere with payment owed for services rendered.

Name of Insured ____ **Relationship to Patient** ___________________
(If different than patient)
Birthdate _________________________ SS # _______________________
Name of Employer _______________________ Union or Local # _______________ Work Phone ______________
Insurance Co. ___________________ Tel. # ______________ GRP# _______________ Policy ID # ______________
Ins Co. Address _______________________________ City ________________ State ____________ Zip __________

Do you have any additional Insurance? [ ] Yes [ ] No **If Yes, complete the following:**

Name of Insured _______________________________________ **Relationship to Patient** ____________________

Birthdate ______________________ SS # __________________________
Name of Employer _______________________ Union or Local # _____________ Work Phone ________________
Insurance Co. ____________________ Tel. # ______________ GRP# _______________ Policy ID # _____________
Ins Co. Address _____________________________ City _______________ State ____________ Zip ____________

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Signature of Patient or Parent/Guardian if Minor