CHART#_____

PATIENT INFORMATION SHEET

PATIENT (Mr. / Mrs. / Ms.) **Date: _____**

First Name: _____ MI _____ Last Name: _____

Sex: M / F Date of Birth: _____ Age: _____ SSN#:_____

Address: _____ City: _____ State: _____Zip: _____

Home Telephone: _____ Cellular Telephone: _____Email:_____

Employer: _____ Business Telephone: _____

Martial Status: Single / Married / Divorced / Widowed / Separated / Other: _____

Referred By: _____ Telephone: _____

Emergency Contact Person:_____Telephone:_____

****

Responsible Party Information: Self / Spouse / Mother / Father / Other: _____

Name: _____ SSN#: _____ DOB: _____

Home Tele: _____ Bus Tele: _____ Cell: _____

Address: _____City: _____State: _____ Zip: _____

Employer: _____ Employer Telephone Number: _____

****

Insurance Company: Primary

Name: _____
Send Claims to: _____
_____
_____
Grp#: _____
Patient ID#:_____

Insured Party:

Name: _____
SSN#: _____DOB: _____
Address: _____
City: _____ State: _____
Zip: _____ Tele: _____
Employer: _____

****

Insurance Company: Secondary

Name: _____
Send Claims to: _____
_____
_____
Grp#: _____
Patient ID#:_____
Is this an Employer Health Insurance Plan: Yes / No

Insured Party:

Name: _____
SSN#: _____DOB: _____
Address: _____
City: _____ State: _____
Zip: _____ Tele: _____
Employer: _____

****

Fees and Payments:

An estimate of the charges for any services you may require will be given to you upon request. If we do not participate with your insurance we will be glad to fill out the proper forms, **but** please complete the identifying information at the top of this form.

****Please** remember that insurance is considered a method of reimbursing the patient for frees paid to the doctor and is not a substitute for payment. It is **your** responsibility to pay any deductible/co-insurance or any outstanding balance not paid for by your insurance company.

**My signature on file is my authorization for the release of information necessary to process my claim(s).

** If this account is turned over to collections, I agree to pay all collection costs, attorney fees, and or court costs.

I HEREBY AUTHORIZE PAYMENT directly to the physician named of the insurance benefits otherwise payable to me. (This is for insurance companies that we participate with.)

SIGNATURE: _____ **DATE: _____**