

PATIENT INFORMATION

Date: _____ Home Phone: () _____ Work Phone: () _____

Patient Name (First): _____ (Middle): _____ (Last): _____

Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

Sex: F M Age: _____ Date of Birth: _____ Single: _____ Married: _____ Other: _____

Patient Social Security #: _____ Driver's License #: _____

Patient Employed by: _____ Occupation: _____

Spouse's Name: _____

Employed by: _____ Business Phone: _____

Social Security #: _____ Date of Birth: _____

Emergency Contact's Name and Number: _____

Primary Physician: _____ Referring Physician: _____

PRIMARY INSURANCE

Insurance Co. Name: _____ Phone #: _____

Address: _____

Name of Policy Holder: _____ SSN#: _____

Relationship to pt: _____ Date of Birth: _____

Insurance ID#: _____ Group #: _____

SECONDARY INSURANCE

Insurance Co. Name: _____ Phone #: _____

Address: _____

Name of Policy Holder: _____

Relationship to Pt: _____ Date of Birth: _____

Insurance ID #: _____ Group #: _____

*****TO BE COMPLETED IF PATIENT IS A MINOR*****

Responsible Party: _____ Phone #: _____

Address: _____

Employer: _____ Business Phone: _____

HIPAA ACKNOWLEDGEMENT

I have received a copy or have been offered a copy of the notice of privacy practices for this doctor's office.

Signature: _____ Date: _____

*****TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN*****

I authorize this practice to submit my records to my insurance company and act as my agent for payment. I am responsible for all balances not covered by insurance. A copy of this may be substituted for the original document.

Name (please print): _____ Medicare #: _____

Signature: _____ Date: _____