PATIENT ACCOUNT INFORMATION

PATIENT

PATIENT NAME_____ ◯MALE ◯FEMALE
LAST FIRST M.I.
PATIENTS ADDRESS_____
STREET CITY STATE ZIP CODE
PATIENTS HOME PHONE (_____) _____-_____ PATIENTS CELL PHONE (_____) _____-_____
PRIMARY CARE PHYSICIAN_____
MARITAL STATUS: ◯SINGLE ◯MARRIED ◯DIVORCED ◯WIDOWED DATE OF BIRTH_____/_____/_____
PATIENT EMAIL ADDRESS: _____ SOCIAL SEC #_____-_____-_____
RACE: _____ ETHNICITY: _____ LANGUAGE: _____
EMPLOYER NAME_____ OCCUPATION_____
EMPLOYER ADDRESS_____ EMPLOYER PHONE # (_____) _____-_____

RESPONSIBLE PARTY

NAME _____ ◯MALE ◯FEMALE
LAST FIRST M.I.
ADDRESS_____
STREET CITY STATE ZIP CODE
HOME PHONE (_____) _____-_____ CELL PHONE (_____) _____-_____
MARITAL STATUS: ◯SINGLE ◯MARRIED ◯DIVORCED ◯WIDOWED DATE OF BIRTH_____/_____/_____
EMPLOYER NAME_____ SOCIAL SEC #_____-_____-_____
EMPLOYER ADDRESS_____ OCCUPATION_____
EMPLOYER PHONE # (_____) _____-_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME_____ ◯HMO ◯PPO ◯PRIVATE
NAME OF INSURED_____
LAST FIRST M.I.
ADDRESS_____
STREET CITY STATE ZIP CODE
INSURED DATE OF BIRTH ____/____/_____ ◯MALE ◯FEMALE SOCIAL SEC #_____-_____-_____
INSURANCE I.D#_____ GROUP # _____
RELATIONSHIP TO PATIENT ◯SELF ◯CHILD ◯SPOUSE ◯OTHER:_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME_____ ◯HMO ◯PPO ◯PRIVATE
NAME OF INSURED_____
LAST FIRST M.I.
ADDRESS_____
STREET CITY STATE ZIP CODE
INSURED DATE OF BIRTH ____/____/_____ ◯MALE ◯FEMALE SOCIAL SEC #_____-_____-_____
INSURANCE I.D#_____ GROUP # _____
RELATIONSHIP TO PATIENT ◯SELF ◯CHILD ◯SPOUSE ◯OTHER:_____

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT PERSON_____ RELATIONSHIP_____
ADDRESS_____
STREET CITY STATE ZIP CODE
HOME PHONE (_____) _____-_____ CELL PHONE (_____) _____-_____ WORK PHONE (_____) _____-_____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits/coverage and tests ordered by my doctor may NOT be covered.** I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that out charges will be paid by the Insurance Company. Insurance is an agreement between you and you insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

PATIENT'S SIGNATURE_____ DATE_____