

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 _____