Patient Information

PERSONAL INFORMATION

Name____

Date of Birth__________ Age____ M/F____ Social Security #________________________

Address____

Street City State Zip

Phone: Home: (__)____________________Work: (___)________________________

E-Mail Address________________________ Occupation________________________

Employer____

Employer's Address____

Marital Status : _______ Spouse Name____

Spouse's Employer________________________Phone(__)________________________

Referred by:____

Complete if under 18 years old or a student

Name of Father____________________ Address ____________________Phone(___)______________

Employer____

Name of Mother ____________________Address____________________ Phone(__)______________

Employer____

INSURANCE INFORMATION

Medicare #____

Workers Compensation (job injury) to whom is bill to be sent?________________________

Other Medical Insurance: Group# __________________ ID#________________________

Name/Address 2nd Insurance____

Are you personally responsible for the payment of your fees? Yes______ No__________________

If not, who is? Name______________________ Relationship_________ DOB__________________

Who to notify in emergency (nearest relative or friend)?

Name________________________Relationship________________________

Address____

Home Phone(__)________________________ Work Phone(___)________________________

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In order to control your cost of billings, we request that your charges for office visit be paid at the conclusion of each visit unless you are covered by Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits of the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED (Patient or parent if minor)____

Date__________________________