PATIENT INFORMATION SHEET

ACCT# ________________

Patient Full Name: ________________________________

Age: _______ Date of Birth: ________________ Sex: *M* *F* SS#: ________________

□ Retired □ Self Employed □ Other Marital Status: *M* *S* *W*

Permanent Address: ________________________________

City: ________________ State: ____________ Zip: ____________ Home Phone: ________________

Local Address: ________________________________

City ________________ State: ____________ Zip: ____________ Local Phone: ________________

Employer: ________________ Address: ________________________________

City ________________ State: __________ Work Phone: ________________ Ext: __________

Emergency Contact: ________________________________ Phone: ________________

Person financially responsible for this account: □ Self □ Spouse □ Parent □ Other (specify) _____

Name: ________________________________ SS#: ________________

Date of Birth: ________________ Work Phone: ________________ Ext: __________

Address: ________________________________

City ________________ State: __________ Zip: __________ Home Phone: ________________

How will you pay for today's services □ Private Pay (payment is due at time of service) □ Insurance □ Other ______

Primary Insurance: ________________________________ Phone: ________________

Address: ________________________________ City/State: ________________ Zip: __________

Policy Holder Name: ________________________________ Date of Birth: ________________

ID#: ________________________________ Group: ________________

Policy Holder's Employer: **(Required)** ________________________________

Secondary Insurance: ________________________________ Phone: ________________

Address: ________________________________ City/State: ________________ Zip: __________

ID#: ________________________________ Group: ________________

REFERRAL SOURCE: (Circle one) DOCTOR FRIEND YELLOW PAGES OTHER __________

PRIMARY CARE PHYSICIAN: ________________________________

Address: ________________________________

City/State: ________________ Zip: ____________ Phone: ________________

IF YOUR INSURANCE COMPANY REQUIRES PREAUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IT IS <u>YOUR RESPONSIBILITY</u> TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THIS, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY.

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper medical care. I authorize the release of any information concerning myself/child/guardian, health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits or to another provider. Use and disclosure of protected health information is regulated by a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization gives our practice permission to disclose the elements of your protected health information.

Patient/Parent/Guardian Signature: ________________________________ ***Date:*** __________