PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name M.I. Last Name

Address City State Zip

Home Phone ( ) Cell ( ) Work ( )

SS# Age DOB

Drivers License # Male ☐ Female ☐

Employer Occupation

Married ☐ Single ☐ Divorced ☐ Name of Spouse

Emergency Contact Telephone ( )

Referred by Friend ☐ Relative ☐ Insurance ☐ Other ☐

PRIMARY INSURANCE Cash ☐ Group ☐ Work/Comp ☐ Auto ☐ Other ☐

Name of Insurance Co. ID#. Group#

Name of Insured Relationship to Patient: Self ☐ Spouse☐ Parent ☐

Secondary Insurance Name of Insured

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understand that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (print) Patient Signature Date

24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE

__________takes pride in the quality of care he offers his patients. In order to do this he has a strict cancellation policy. Dr. __________ requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged to the credit card we have on file.

I, ______________________________________ authorize Dr. ________ to charge the credit card given below, for cancellation fees, insurance co-payments and related charges.

____________-______________-_______________-_________________ Ex______/_______ Visa ☐ / MC ☐

Patient Name (print) Patient Signature Date

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