|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION RECORD** | | | | **Referring Doctor Date** | | | | | | | |
| **Patient's Name** | | | | **Marital Status** | | **Date of Birth** | | | **Age** | | **Sex** |
| **Street Address** | | | | **Home Phone** | | **Cell Phone** | | | **Social Security No.** | | |
| **City, State, Zip Code** | | | | **Spouse's Name** | | | | | | **Date of Birth** | |
| **Patient's Employer** | | | **Business Phone** |  | | | | | | | |
| **Patient's Occupation** | | | |  | | | | | | | |
| **Insurance # 1** | | | | **Name of Insured Date of Birth:** | | | | | | | |
| **Insurance #2** | | | | **Name of Insured Date of Birth:** | | | | | | | |
| **Relative or Friend (Not Living With You)** | | | **Address** | | | | **Phone No.** | | | | |
| **Are you HIV Positive?**  **YES NO** | **Do You Have any drug allergies?**  **No Yes If yes Explain** | | | | **Do You Have Any Serious Medical Problems?**  **No Yes If yes Explain** | | | | | | |
| **I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER AND PAYMENT DIRECTLY TO MY PHYSICIAN FOR ALL SERVICES LISTED ON THE AITACHED HEALTH INSURANCE CLAIM FORM. I UNDERSTAND THAT SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY.** | | | | | | | | | | | |
| **Email Address:**  **Patient or Parent's Signature** | | | | | | | | | | | |
| **IF PATIENT IS A MINOR** | | | | | | | |  | | | |
| **Person Responsible for Payment** | | | | **Relationship** | | | | **Phone** | | | |
| **Mother** | | | **Date of Birth** | **Father** | | | | **Date of Birth** | | | |
| **Social Security No.** | | | | **Social Security No.** | | | | | | | |
| **Address, City, State, Zip Code** | | | | **Address, City, State, Zip Code** | | | | | | | |
| **Home Phone** | | **Work Phone** | | **Home Phone** | | | | **Work Phone** | | | |
| **Employer** | | | | **Employer** | | | | | | | |
| **REFERRAL SOURCE:** | | | | | | | | | | | |
| **Friends Internet Commercial/Billboard Physician**  **Other** | | | | | | | | | | | |