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| **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** |