Patient Information

(Please Print)

Today's Date ____/____/____ (Month Day Year) How would you like to be addressed: ☐Mr. ☐Mrs. ☐Ms. _____

Name _____ (Last Name / First Name / Middle Initial) Occupation _____

Mailing Address _____ (Street / City / State / Zip Code)

Primary Phone _____ (Area Code / ext.) Secondary Phone _____ (Area Code / ext.) ☐Single ☐Married ☐Divorced ☐Separated

Birth Date ____/____/____ (Month Day Year) Age _____ Sex ☐ M ☐ F Social Security # (last 4 digits only) _____

If Student: ☐Full Time or ☐Part Time Name of School _____ e-mail _____

PARENT OR RESPONSIBLE PARTY *(If different from patient)*

Name _____ (Last Name / First Name / Middle Initial)

Address *(If different from above)* _____ (Street / City / State / Zip)

Primary Phone _____ (Area Code / ext.) Secondary Phone _____ (Area Code / ext.) SS# (last 4 digits only) _____

Birth Date ____/____/____ (Month Day Year) Sex ☐ M ☐ F

INSURANCE INFORMATION (Please present insurance card at time of check in.)

You can omit filling out this box if you already presented your insurance card

Primary Ins. Name _____

Ins. Address _____

Name of Insured _____ DOB: _____

Insured's ID # _____

Group / Account # _____

Employer Name _____

Employer Address _____

Employer Phone _____ (Area Code)

Relationship of patient to the Insured _____

If Applicable, please indicate if you have a secondary insurance plan and present to us your card

Secondary Ins. Name _____

Ins. Address _____

Name of Insured _____ DOB: _____

Insured's ID # _____

Group / Account # _____

Employer Name _____

Employer Address _____

Employer Phone _____ (Area Code)

Relationship of patient to the Insured _____

Other family members that are patients: _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ (Relationship) Phone _____

Whom may we thank for referring you? _____ (Relationship)

Primary Care Physician _____

I have read the **Notice of Privacy Practices** and consent to the use of my medical records as described. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I acknowledge that I can request a copy of **Notice of Privacy Practices** if I wish to keep one.

Patient or Responsible Party Signature _____ Date ____/____/____

Please be aware of your financial responsibilities for your office visit, i.e. you are responsible for knowing your own policy insurance policy, especially regarding copay, co-insurance, and deductible. We ask that payment is made at the time service is rendered unless you are in an HMO/PPO in which we participate. By law, we are required to collect any copayment or deductible that is due. We accept payment in the form of cash, check, or major credit card. Please be aware you may have a deductible for office procedures that is at a higher limit than your office visit. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____/____/____