PATIENT INFORMATION

Patient Name:_____Today's Date: _____

Address: _____ Home Phone: _____ Cell: _____

City: _____ State: _____ Zip Code: _____Work Phone: _____

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____ Marital Status: M S D W

Highest Level of Education: ❑ Partial HS ❑ HS ❑ Partial College ❑ College ❑ Advanced Degree

Employer Name: _____Occupation:_____ How Long?_____

Employer Address:_____

City: _____State:_____Zip Code: _____

Previous Employer (If less than 2 yrs): _____

Referring Physician's Name & Address: _____

Telephone: _____ _____

Person to Contact in an Emergency _____

Relationship to patient:_____ Telephone:_____

Nearest relative or friend not living in household: _____

Relationship to patient:_____ Telephone:_____

Primary Insurance Co. _____ID#_____

Address _____Telephone _____

Insured's Name _____ Relationship_____Group# _____

DOB:_____ Sex: _____ SS#_____ Employer: _____

Secondary Insurance Co._____ID#_____

Address _____Telephone _____

Insured's Name _____ Relationship_____Group# _____

DOB:_____ Sex: _____ SS#_____ Employer: _____

Please indicate how we may contact you for appointments. Please note: We will not conduct any other communications about your treatment other than appointments via text messaging, or email.

Preferred method of contact: Phone: _____ Cell Phone (Text): _____

Email Address:_____

To avoid misunderstandings, you should be aware that, generally, you are responsible for all charges regardless of whether your insurance reimburses for services. In certain instances, such as with a preferred provider plan, HMO, or Medicare assignment, the insurance would reimburse me directly. However, you are still responsible for any deductibles and co-payments.

Appointments are made and the time held for you. If you miss your appointment, or you cancel with less than 48 hours notice, and the appointment cannot be filled, a charge will be made which is not reimbursable by insurance.

By signing this form, I authorize release of any medical information necessary to process insurance claims on my behalf. I accept full responsibility for payment of all services rendered as described above. I agree to pay all collection costs and reasonable attorney's fees should I default on my payments and force collection of my debt.

Signature:_____ Date: _____