



**PATIENT INFORMATION**

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_  
City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

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

Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Other family members that are patients \_\_\_\_\_

In case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician's Name	Address	Phone #
_____	_____	_____

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.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. **In the event that your account must be turned over to collections, a \$25.00 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**All paperwork must be completed and received in our office 5 days prior to your appointment, or you will be asked to reschedule. Emergency situations may be deemed an exception.**