

PATIENT ACCOUNT INFORMATION

Responsible Party

Name: _____
Last First M. I.
Address: _____
Street City State Zip
Home Phone: (____) _____ Business Phone: (____) _____ Date of Birth: _____
Month / Day / Year
Referred By: _____ SS #: _____ Driver's License Number: _____
Have you or any family member been seen here before? Yes No E-mail Address: _____

Patient

Patient Name _____ Male Female
Last First M. I.
Physician you are here to see _____
Marital Status: Single Married Divorced Widowed Date of Birth: _____
Month / Day / Year
Employer Name: _____ Social Sec. #: _____
Employer Address: _____ Occupation: _____
Business Phone #: (____) _____ Pharmacy Phone #: (____) _____ Retirement Date: _____

Primary Insurance Information

Insurance Company Name _____ HMO PPO Private
Name of Insured _____
Last First M. I.
Address _____
Street City State Zip
Date of Birth (Insured) _____ Male Female
Month / Day / Year
Social Security Number: _____ Insurance ID #: _____
Group Number: _____ Employer: _____ Occupation: _____
Relationship to Patient: Self Parent Spouse Other : _____

Secondary Insurance Information

Insurance Company Name _____ HMO PPO Private
Name of Insured _____
Last First M. I.
Address _____
Street City State Zip
Date of Birth (Insured) _____ Male Female
Month / Day / Year
Social Security Number: _____ Insurance ID #: _____
Group Number: _____ Employer: _____ Occupation: _____
Relationship to Patient: Self Parent Spouse Other : _____

Accident Information

Accident Date: _____ Time: _____ Place: _____
Accident Detail: _____

Emergency Contact Information

Name of Person to Contact: _____ Relationship _____
Address _____
Street City State Zip
Home Phone (____) _____ Work Phone (____) _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All Co-pays, cosmetic procedures, and other non-covered services are to be paid at the time of service. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's Signature: _____ Date: _____