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PATIENT INFORMATION (PLEASE PRINT)

Date:__________________________201__

Patient's Name:____

Date of Birth:____________________________________ Age: _____ Sex: ❑M ❑F

Email:____

Person Responsible for Bill:____

Address:____Apt_______Home Phone: (____)______________

City: ______________________________________ State:_____ Zip:___________ Mobile:______________________

Marital Status of Parents: ❑ Married ❑Divorced ❑Separated ❑Other:________________________

Father's Name:____ S.S.#______________________

Name and Address of Employer:____

____Phone: (____)________________

Mother's Name:____ S.S.#______________________

Name and Address of Employer:____

____Phone: (____)________________

Name and Address of Friend or Relative not Living with You:____

____

Relationship:____Phone: (____)__________________

Reffered By:____ Pharmacy Phone #: (____)_________________

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INSURANCE INFORMATION

Name of Insured:____

Name of Insurance Company:____ Phone: (____)_________________

I.D. Number:______________________________________ Group Number:___________________________________

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MEDICAID PATIENTS

Medicaid Number:____

Name of Caseworker:____

I will be financially responsible for all medical expenses for the above patient in the event they should be dropped from Medicaid coverage during the course of treatment. **Sign Here** ____

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PLEASE READ: All professional services are charged to the ***patient.*** Payment is requred ***in full*** at the time of each visit if we do not have the proper insurance information. We bill only in connection with hospitalization unless you have one of our approved HMO/PPO insurance cards or medicaid card. You are responsible for all fees, regardless of insurance coverage. We will supply you with all the information necessary for you to file your insurance for reimbursement.

AUTHORIZATION:

I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours notice.
All of the office policies have been explained to me and I understand that all insurance copays, insurance deductibles, or charges for office visits without insurance are to be paid in full at the time of service.

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the undersigned physician or supplier for services described below:

Signed____ **Date**________________________201__

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