PATIENT INFORMATION FORM

WELCOME TO OUR OFFICE

Today's Date:_____ Updated: _____

LAST NAME	FIRST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP
MAIL ADDRESS (If Different)	CITY	STATE	ZIP
SOCIAL SECURITY#	DATE OF BIRTH		AGE
MARITAL STATUS **M S D W**	SEX **M F**	DRIVERS LICENSE #:	
HOME PHONE	WORK PHONE	OCCUPATION	
EMPLOYER			

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME		MI
MAIL ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO PATIENT	PHONE		

INSURANCE INFORMATION

PRIMARY INSURANCE	INSURED NAME		
Social Security #	Date of Birth		SEX **M F**
Mail Address	City	State	Zip
ID#	GROUP#	PHONE	

PLEASE PRESENT RECEPTIONIST WITH YOUR INSURANCE CARD

SECONDARY INSURANCE	INSURED NAME		
Social Security #	Date of Birth		SEX **M F**
Mail Address	City	State	Zip
ID#	GROUP #	PHONE	

YOUR CO-PAY IS DUE AT THE TIME OF SERVICE. THANK YOU!

Reason for seeing the doctor today	
Referred By	Preferred Pharmacy

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to: _____ for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. _____ (Please initial)

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or the intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, the physician/supplier accept the charge determination of the Medicare/Other insurance company as the full charge (excluding non-contracted insurance), and the patient is only responsible for the deductible, coinsurance, co-payment or non-covered services.

SIGNATURE:_____ PRINT NAME:_____DATE:_____