PATIENT INFORMATION

Patient (Legal) Name: ______________________________

(Preferred Name): ____________ **Previous/Maiden Name(s):** ____________

Social Security #: ____________ **Birth Date:** ____________

Male: ☐ **Female:** ☐ **EMAIL ADDRESS:** ____________

Physical Address: ______________________________

Mailing Address: ______________________________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Patient's Employer: ____________ **Work Phone:** ____________

Spouse Name: ____________ **Phone:** ____________ **Spouse Soc. Sec. #:** ____________

Spouse Birth Date: ____________ **Spouse Employer:** ____________ **Spouse Work phone #:** ____________

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A STUDENT

Mother's Name: ____________ Father's Name: ____________

Mother's Social Security #: ____________ Father's Social Security #: ____________

Address: ______________________________

Mother's DOB: ____________ Employer: ____________ Work Phone #: ____________

Father's DOB: ____________ Employer: ____________ Work Phone #: ____________

NEAREST RELATIVE/FRIEND NOT LIVING WITH PATIENT

Name: ____________ **Relationship:** ____________

Address: ____________ **Phone #:** ____________

WHO CAN WE THANK FOR REFERRING YOU TO US?

☐ **Doctor** ☐ **Family/Friend** ☐ **All other:** ____________

IMPORTANT INFORMATION (PLEASE READ)

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered an agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE: ____________ **DATE:** ____________

PATIENT OR GUARDIAN SIGNATURE: ____________ **DATE:** ____________

☐ **CHECK HERE IF YOU WOULD LIKE TO RECEIVE PAPER STATEMENTS EACH MONTH**