WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help you.

1. Patient Information

Date ______________

Name: ______________________________ I prefer to be called: ______________________

Address: ______________________ City: ______________ State: ________ Zip: __________

Date of Birth: __________ Social Security # ______________________________

Phone (____) ____________ Work Phone (____) ______________ Cell Phone (____) ______________

The best time to contact me is: __________ ☐ A.M. ☐ P.M. on my ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Preferred Pharmacy: ____________________________ Address: ________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Other ☐ Pacific Islander ☐ Declined

Ethnicity: ☐ Non-Hispanic ☐ Hispanic Language: ______________________________

Sex: ☐ Male ☐ Female

2. Responsible Party

Who is responsible for the account?

Name: ____

Relationship to patient: ____

Birthdate: ______________________ Driver's License# ______________________________

Social Security#: ____

Address: ____

City, State, Zip: ____

Employer: ______________________ Occupation: ______________________________

Work Phone (____) ______________________ Home Phone (____) ______________________

3. Emergency Contact

In an emergency, who should we contact?

Name: ____________________________ Relationship: ____________________________

Work Phone (____) ______________________ Home Phone (____) ______________________

4. Insurance Information

Primary Insurance	Additional Insurance
Name of Insured:________________	Name of Insured:________________
Relationship to patient:________________	Relationship to patient:________________
Insured's birthdate:________________	Insured's birthdate:________________
SS#:________________	SS#:________________
Employer:________________	Employer:________________
Date Employed:________________	Date Employed:________________
Occupation:________________	Occupation:________________
Insurance Company:________________	Insurance Company:________________
Group #:________________	Group #:________________
Employee/Cert.#:________________	Employee/Cert.#:________________
Ins. Co. Address:________________	Ins. Co. Address:________________
Deductible:________________	Deductible:________________
Amount already used:________________	Amount already used:________________
Max Annual benefit:________________	Max Annual benefit:________________

5. Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient or parent if minor **Date**

6. Financial Arrangements

For your convenience, we offer the following methods of payment.
Please check the option which you prefer.
Payment in full at each appointment.

__________ Cash

__________ Personal Check

__________ Credit Care _______ Visa _______MC

__________ I wish to discuss the office's payment policy.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.