Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions to the best of your knowledge. If you need help please ask the receptionist. PLEASE PRINT.

Name:____Today's Date:______________________

Address:______________________________City:_________________State:_______Zip:__________________

Home Phone:_________________ Cell phone:_________________ Work Phone:________________________

Age:_____ D.O.B. :_____________ Maritial Status: S M W D

Social Security Number: ____________________Email:____

In Case of Emergency
Name:_______________________________________ ____ Relationship:______________________
Home Phone:_________________ Cell phone:_________________ Work Phone:__________________

Employer: _____________________________ Occupation: _____________________Yrs. On Job:______________

Address:______________________________City:_________________State:_______Zip:___________________

Insurance Provider: ___________________________________ Member ID #:____________________________

Plan/Group #: _______________________ Primary Person Insured: ______________________________ D.O.B. : ______________

S.S.N.:___________________________________ Employer Name: ____________________________________

Secondary Insurance Provider: ___________________________________ Member ID #:___________________

Plan/Group #: _______________________ Primary Person Insured:___________________________________ D.O.B. : ______________

S.S.N. :___________________________________ Employer Name: ____________________________________

How did you hear about us: TV / Radio / Sign / Friend or Family / Flyer / Other _____________________________

If referred, please tell us who we can thank: ____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ____ Date: _________________________

Spouse or Guardian Signature: ___________________________________ Date: _____________

Notice to New Patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made prior to seeing the doctor.