Patient Information Sheet
Welcome to our Office…

***Attention*:** Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Printer friendly version

Social Security#

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) **Gender:** **Marital Status:**

_____ / _____ / _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Address: **Apt.#:** **City:** **State:** **Zip:**

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

(_____) _____ (_____) _____ (_____) _____

Emergency Contact: **Emergency Telephone#:**

(_____) _____

Employer Name: **Employer's Address / City / State / Zip**

Referring Doctor: **Referring Dr.'s Address / City / State / Zip** **Ref. Dr. NPI #**

Primary Care Physician: **Primary Care Physician's Address / City / State / Zip** **P.C.P. NPI #**

Primary Insurance Company Information:	**Secondary Insurance Company Information:**
Policy Holder First Name:	**Policy First Name:**
Policy Holder Last Name:	**Policy Holder Last Name:**
Policy Holders Date of Birth:	**Policy Holders Date of Birth:**
Policy Holders SS# _____-_____-_____ _____ / _____ / _____	**Policy Holders SS#** _____-_____-_____ _____ / _____ / _____
Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other	**Gender:** ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐ **Same as patient**	**Policy Holder's Address:** ☐ **Same as patient**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Insurance's Name:	**Insurance's Name:**
Policy ID: **Group #:**	**Policy ID:** **Group #:**
Claim Submission Address:	**Claim Submission Address:**
Effective Date: _____ / _____ / _____	**Effective Date:** _____ / _____ / _____
Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____	**Do you have a Co-pay?** ☐ No ☐ Yes, Amt $_____
Referral Required: ☐ **Yes** ☐ **No**	**Referral Required:** ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): **Responsible Party's SSN:** **Relationship to Responsible Party:**

___-__-_____ ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

The Practice accepts personal checks. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), a fee of $25 will be applied.

All patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel 24hrs prior to an appointment (no show) will result in a $25 fee.

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date:_____ Patient's Signature (or parents if under 18 years of age): _____

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