PATIENT ACCOUNT INFORMATION

Patient

Patient Name _____ DOB _____ ☐ Male ☐ Female
Last First M. I.

Address: _____ City: _____ State: _____ Zip Code: _____

Physician you are here to see _____ Referred by: _____

Have you or any family member been seen here before? ☐ Yes ☐ No Patient Home Phone Number: _____

Responsible Party

Father Name: _____ Occupation _____ Employer: _____

DOB: _____ Home Address: _____ Phone #: H: _____ W: _____
Cell: _____

SS #: _____ Marital Status: Single: ☐ Married: ☐ Widowed ☐ Divorced: ☐

Mother Name: _____ Occupation: _____ Employer: _____

DOB: _____ Home Address: _____ Phone #: H: _____ W: _____
Cell: _____

SS #: _____ Marital Status: Single: ☐ Married: ☐ Widowed ☐ Divorced: ☐

Guardian: _____ Occupation: _____ Employer: _____

DOB: _____ Home Address: _____ Phone #: H: _____ W: _____
Cell: _____

SS #: _____ Marital Status: Single: ☐ Married: ☐ Widowed ☐ Divorced: ☐

Primary Insurance Information

Insurance Company Name _____ HMO☐ PPO☐ Private☐

Insurance Address _____ City _____ State _____ Zip Code _____

Name of Insured _____
Last First M. I.

Insurance ID # _____ Group Number _____

Secondary Insurance Information

Insurance Company Name _____ HMO☐ PPO☐ Private☐

Insurance Address _____ City _____ State _____ Zip Code _____

Name of Insured _____
Last First M. I.

Insurance ID # _____ Group Number _____

Emergency Contact Information

Name of Person to Contact Other than Parent: _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's Signature: _____ Date: _____