PATIENT INFORMATION FORM

FULL LEGAL NAME _____

SOCIAL SECURITY # _____ **DOB** _____ **SEX** _____

EMPLOYER _____ **TELEPHONE #** _____

In case of an emergency, who should be notified? _____

Telephone _____

REFERRED BY: _____

RESPONSIBLE PARTY OR LEGAL GUARDIAN ***(ONLY IF PATIENT IS A MINOR)***

FULL NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

TELEPHONE (HOME) _____ **(CELL)** _____

EMPLOYER _____

EMPLOYER TELEPHONE NUMBER _____

It is the policy of this office that the adult presenting the child for treatment is responsible for the payment of the patient at the time of service.

Insurance Information

SUBSCRIBER S. S. # _____

PRIMARY INSURANCE NAME _____

SECONDARY INSURANCE NAME _____

TERTIARY INSURANCE NAME _____

I authorize the medical information to my primary care or referring physician to consultants if needed and as necessary to process insurance claims. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and to avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. For those patients, applicable co-payments and deductibles will be collected. All non-covered or cosmetic procedures are payable in full at time of service. We accept payment in the form of cash, check or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Responsible Party or Legal Guardian Signature _____

Date _____