Office Use Only

Date_____Doctor_____Acct#_____ M___F____ E-Script____

PATIENT FINANCIAL INFORMATION

PATIENT NAME _____
LAST FIRST MI
DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY_____-_____-_____

MAILING ADDRESS_____
Number and Street City, State, Zip Code +4digit postal code

HOME PHONE_____CELL_____E-MAIL_____

EMPLOYER_____

EMPLOYER ADDRESS_____CITY/STATE/ZIP_____

Who can we thank for referring you to our office? _____

FAMILY DOCTOR_____CITY OF LOCATION_____
Circle the appropriate status: Single Married Divorced Widow

INSURANCE INFORMATION

PRIMARY INSURANCE_____INSURED'S NAME_____
SECONDARY INSURANCE _____INSURED'S NAME_____

SPOUSE OR RESPONSIBLE PARTY

NAME_____RELATIONSHIP_____

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY_____-_____-_____

EMPLOYER _____ _____EMP PHONE_____

BUSINESS ADDRESS_____CITY, ST, ZIP_____
We are required to maintain the privacy of your Health Information (HIPAA). Please advise who we may disclose your information to: Name: _____Relationship_____

EMERGENCY CONTACT_____
PHONE _____RELATIONSHIP_____
Preferred Pharmacy_____Location_____

I authorize and release any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician and agree that I am responsible for any balance of my account for any professional services rendered.
Signature_____ Date: _____