

**PATIENT INFORMATION FORM**

**PATIENT INFORMATION:**

Full (legal) Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_  
Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_  
SS#: \_\_\_\_\_

**SPOUSE :**

Full Name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Phone#: \_\_\_\_\_  
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Cell #: \_\_\_\_\_

**Whom may we contact in case of emergency?**

Phone#: \_\_\_\_\_

**Nearest Relative not living with you?**

Phone#: \_\_\_\_\_

**PATIENT EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Employer Phone #: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

Insurance Co. Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ DOB \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address Where Claims are to be mailed: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

Insurance Co. Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ DOB \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address where claims are to be mailed: \_\_\_\_\_

**Please check (✓) which method would be best to contact you for an appointment reminder?**

Home phone     Cell phone     TEXT Message     Work phone     Email     Regular mail

**Please check (✓) which method would be best to contact you for a billing statement?**  Regular mail     Email

I authorize the release of medical or other information about me to the above listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

**Copays, co insurance, and/or deductibles are due at time of service unless other arrangements have been made.** All accounts should be paid within 90 days of insurance being posted to prevent further action. I agree to pay any collection or attorney fees owed in addition to court costs if charges are not paid within the agreed upon terms and legal action is necessary to effect collection.

I certify that I have read all of the above and the information given is true.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_