PATIENT ACCOUNT INFO[illegible]MATION

Responsible Party

Name: _____ (Last / First / M. I.)

Address: _____ (Street / City / State / Zip)

Home Phone: (___)_____ Business Phone: (___)_____ Date of Birth: _____ (Month / Day / Year)

Referred By: _____ Phone #: _____ SS #: _____ Driver's License Number: _____

Have you or any family member been seen here before? ☐ Yes ☐ No E-mail Address: _____

Preferred Pharmacy _____ Address _____ Phone _____

Patient

Patient Name _____ (Last / First / M. I.) ☐ Male ☐ Female

Physician you are here to see _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth: _____ (Month / Day / Year)

Employer Name: _____ Social Sec. #: _____

Employer Address: _____ Occupation: _____

Business Phone #: (___)_____ Retirement Date: _____

Primary Insurance Information

Insurance Company Name _____ ☐ HMO ☐ PPO ☐ Private

Name of Insured _____ (Last / First / M. I.)

Address _____ (Street / City / State / Zip)

Date of Birth (Insured) _____ (Month / Day / Year) ☐ Male ☐ Female

Social Security Number: _____ Insurance ID #: _____

Group Number: _____ Employer: _____ Occupation: _____

Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other : _____

Secondary Insurance Information

Insurance Company Name _____ ☐ HMO ☐ PPO ☐ Private

Name of Insured _____ (Last / First / M. I.)

Address _____ (Street / City / State / Zip)

Date of Birth (Insured) _____ (Month / Day / Year) ☐ Male ☐ Female

Social Security Number: _____ Insurance ID #: _____

Group Number: _____ Employer: _____ Occupation: _____

Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other : _____

Accident Information

Accident Date: _____ Time: _____ Place: _____

Accent Detail: _____

Emergency Contact Information

Name of Person to Contact: _____ Relationship _____

Address _____ (Street / City / State / Zip)

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: _____