

## PATIENT INFORMATION

Insurance companies require us to update all of your information annually, even if none of your information has changed. This also helps keep our office updated on how to reach you/relative for emergencies. Please fill out this sheet in entirety. Thank you for your time and understanding.

- General Information**

**EMAIL:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Cell Phone # (opt.):** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Spouse/Partner's Name:** \_\_\_\_\_ **Spouse/Partner's SS#:** \_\_\_\_\_

**Spouse/Partner Date of Birth:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Contact in Case of Emergency:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Referral Source:**  **Physician:** \_\_\_\_\_  **Yellow Pages**  **Friend**  **Relative**  **Co-Worker**

- Insurance Information**

**Primary Insurance:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Policy/Member ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Policy/Member ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

- If Patient is Covered Under Parent/Guardian's Policy:**

**Mother's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Mother's Employer:** \_\_\_\_\_ **Home Phone#:** \_\_\_\_\_ **Bus. Phone#:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Father's Employer:** \_\_\_\_\_ **Home Phone#:** \_\_\_\_\_ **Bus. Phone#:** \_\_\_\_\_

- Please Read and Sign Below:**

- I understand that it is my responsibility to obtain any necessary referral or authorization from my insurance carrier.
- I understand that I am financially responsible for any services rendered, with or without a referral, regardless of the contractual agreement between the insurance carrier and my physician.
- I hereby authorize my physician to release any medical information to my insurance carrier(s) in regards to services rendered and assign benefits payable to me and my physician.
- A copy of the brochure "Notice of Privacy Practices for Protected Health Information" has been provided to me by this office.

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_