Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insurance Name and Address: _____

Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insurance Plan Name and Address: _____

_____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Consent for Services

Patients who carry insurance understand that all services furnished are charged directly to the patient and that he or she is personally responsible for payment of all services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I herby authorize payment directly to the provider of medical services from any hospital/medical insurance benefits, or benefits payable from any other entity payable to me. This authorized payment shall not exceed the balance due of the provider's regular charges for this period of hospitalization/medical services.

I herby authorize release of information by all providers of services for all or part of the patient's record to any person or corporation which is or may be liable under contract to the provider or the patient for all or part of the provider's charge. A copy of this is as valid as the original.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party