PATIENT INFORMATION SHEET

Name: ____ Date: ___/___/___
Last *First* *M.I.*
Address: ____
Street *City* *St* *Zip*
Phone: ____
Home *Work* *Cell*
Email Address: ____
Date of Birth: ___/___/___ Age: ____ Sex: ____ SS#: _________________________
Name of Employer: ______________________ Address: _______________________

Parent, Spouse, or Responsible Party (If different from patient)
Name:____
Last *First* *M.I.*
Address: ____
Street *City* *St* *Zip*
Phone: ____
Home *Work* *Cell*
Name of Employer: ______________________ Address: _______________________
Date of Birth: ___/___/___ Age: ____ Sex: ____ SS#: _________________________

Primary Ins Name: ____________________ Address:__________________________
Phone: ________________________ Policy Holder Name:______________________
ID#:____________________Group#:______________Relationship to Patient:______

Secondary Ins Name:____________________Address:__________________________
Phone:_________________________Policy Holder Name:______________________
ID#:____________________Group#:______________Relationship to Patient:______

Primary Care Physician:__________________________Phone #:__________________
Referred by:__________________________________ Phone #:__________________
In case of emergency, contact:____________________ Phone #:__________________

By signing below, I authorize the release of medical information to my primary care or referring physician, to consultants for claim processing or prescriptions. I also authorize payment of medical benefits to the physician. I understand payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, **all applicable deductibles, co-payments, and coinsurance will be collected at the time of service. Any fees for non-covered services will also be collected at the time services are rendered**. I understand that there is a **$50 NO SHOW FEE** for all missed appointments that are not cancelled or rescheduled**.** Your signature below signifies your understanding and willingness to comply with our above policies.

Patient or Responsible Party Signature:__________________________Date:_________