

PATIENT INFORMATION

Please print

Date: _____

LAST NAME	FIRST	INITIAL	Preferred Name
Marital Status	Birth Date	Age	Home Phone
Mailing address	City	State	Zip Code
Patient's Employer	Occupation (indicate if student)	Bus. Phone #.	Ext.
Employers Street Address	City/State	Zip Code	
How did you choose our office?	Primary Care Physician:		
Other Phone #'s / Cell:			
Spouse's / Partner's Name	Birth Date		
Spouse's / Partner's Employer	Occupation (indicate if student)	Bus. Phone #	Ext.
If patient is minor/ please complete Mother or Father	Birth Date		
Parent Employed by:	Employer Street Address	Bus. Phone #/ Ext.	
Emergency Contact (other than listed above)	Cell Phone:		

Other: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. I affirm that the information I have given today is correct to the best of my knowledge. I give permission for release of any medical information necessary for my care or requested by my insurance company to process my claims, per HIPAA guidelines, as enacted by this office. I agree to these policies, and written information of the policies was made available to me.

Signature _____ Date _____