

PATIENT INFORMATION SHEET

PERSONAL INFORMATION:

First Name: _____ Initial: _____ Last Name: _____

Sex: _____ Date of Birth: _____ Age: _____ SS# _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

E-mail: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Employer: _____ Address: _____

Spouse's Name: _____ Spouse's DOB: _____ SS# _____

Spouse's Employer: _____ Spouse's Cell: _____ Work# _____

Father's Name (if pt is minor): _____ DOB: _____ SS# _____

Father's Address: _____ Phone: _____

Mother's Name (if pt is minor) _____ DOB: _____ SS# _____

Mother's Address: _____ Phone: _____

Referring Physician: _____ Address: _____ Phone: _____

INSURANCE INFORMATION:

Workers Compensation: ___ Yes ___ No Claim# _____

Primary Insurance: _____ Phone: _____

Address: _____

ID# _____ Group# _____

Group Name: _____ Co-pay: _____

Insured Party: _____ Relationship to Patient: _____

Secondary Insurance: _____ Phone: _____

Address: _____

ID# _____ Group# _____

Group Name: _____ Co-pay: _____

Insured Party: _____ Relationship to Patient: _____

ASSIGNMENT:

I hereby assign my insurance benefits to be paid directly to my Doctor. I understand I am responsible for all charges, whether or not paid by insurance. I also understand payment is due at time of service.

Date: _____

Patient Signature (Parent or Guardian if Minor)