

# PATIENT INFORMATION SHEET

DATE
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REFERRED BY: \_\_\_\_\_

Name of Patient \_\_\_\_\_ Marital Status: (circle) S M D W P  
Last First MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone: \_\_\_\_\_ CELL \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Patient's Sex: Male Female Patient's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Spouse's Name \_\_\_\_\_ Spouse's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

<b>PERSON TO CALL IN CASE OF EMERGENCY</b>
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Name	Address	Phone	Relationship

Although services may be covered by insurance, I understand that I am fully responsible for payment for the care I receive. I understand an administrative service charge of 1% or \$1.50 per month, whichever is greater, will be charged on all unpaid balances. I authorize payment of medical benefits to my practitioner for services rendered. I authorize the practitioner or insurance to release any information required for services rendered by this office. **I further understand there is a 24 hour cancellation policy and I will be billed if I fail to give the requisite notice. This fee is currently \$50.00 and not covered by insurance.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**WE WILL NEED A COPY OF YOUR INSURANCE CARDS**

INSURANCE	<b>PATIENT INSURANCE (PRIMARY)</b>		<b>ADDITIONAL INSURANCE (SECONDARY)</b>	
	NAME OF INSURED		NAME OF INSURED	
	RELATION TO PATIENT		RELATION TO PATIENT	
	BIRTHDATE	EMPLOYER	BIRTHDATE	EMPLOYER
	INSURANCE COMPANY		INSURANCE COMPANY	
ID/SS NUMBER	GROUP NUMBER	ID/SS NUMBER	GROUP NUMBER	