PATIENT INFORMATION

Please complete and return the following form to our office at least 24 hours PRIOR to you appointment.

Date:_____ Patient Name _____
FIRST M.I. LAST

SS # _____ ○ Male ◉ Female Date of Birth _____ Driver's License # _____

Address_____ City_____ State_____ Zip code _____

E-Mail_____ Work Phone_____

Home Phone_____ Cell Phone _____

Marital Status: ○ Single ◉ Married ○ Divorced ○ Separated ○ Widowed

Ethnic Group: ○ Hispanic or Latino ◉ Non-Hispanic or Latino

Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian
☐ Native Hawaiian or Other Pacific Island ☐ Other

Preferred Language: ○ English ○ Spanish ○ Other _____

Name of Primary Physician_____ Phone_____

Address of Primary Physician_____ City_____ State_____ Zip code _____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Insurance Information

Name of Insured_____ Relationship to patient _____

Date of Birth_____ SS # _____

Insurance Company_____ Group #_____ Insurance ID # _____

Do you have any additional insurance? ○ No ○ Yes - Please complete the following:

Name of Insured_____ Relationship to patient _____

Date of Birth_____ SS # _____

Insurance Company_____ Group #_____ Insurance ID # _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for allowing us to be a part of your healthcare. It is our desire to provide the highest quality care for our patients. The established financial policy of this office is that full payment is due at the time of service, except for those using insurance or a payment plan. The following is a statement of our Financial Policy which we require that you read, agree to and sign before any treatment.

PAYMENT OPTIONS – We accept cash, checks (up to $400), MasterCard, Visa and Discover. Returned checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 60 days and failure to pay as promised may be subject to external collection and additional collection fees.

CANCELLATION POLICY – We require a 24hour notice for appointment cancellation. **Failure to show for a scheduled confirmed appointment will result in a $50 cancellation fee.**

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**