## PATIENT INFORMATION (Please Print) Today's Date___/___/___

Name_____
*Last* *First* *M.I.*

Primary Mailing Address_____
*City* *State* *Zip*

Home Phone_____Work Phone_____ Cell Phone_____
*Area Code* *Area Code* *Area Code*

Date of Birth___/___/___ Age____ Sex____ Marital Status_____

Secondary Mailing Address_____
*City* *State* *Zip*

Home Phone_____ Work Phone_____
*Area Code* *Area Code*

Occupation _____

## PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name_____
*Last* *First* *M.I.*

Address_____
*City* *State* *Zip*

Home Phone_____ Work Phone_____
*Area Code* *Area Code*

Date of Birth___/___/___ Age___ Sex___

### Insurance Information *(Please present insurance card at time of check in).*

***Primary*** Insurance Name_____

***Secondary*** Insurance Name_____

Relationship of patient to the insured_____

Pharmacy of choice_____ Phone number_____
*Area Code*

In case of emergency, who should be notified?_____Phone number_____
*Area Code*

Primary Care Physician_____Phone number_____
*Area Code*

Referred by:_____Phone Number_____
*Area Code*

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

**Patient or Responsible Party Signature**_____ **Date___/___/___**

Payment is required for all services at the time they are rendered unless you are in a plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. You will be responsible for any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

**Patient or Responsible Party Signature**_____ **Date___/___/___**