

PATIENT INFORMATION FORM

LAST NAME _____ FIRST _____ MI _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX _____
AGE _____ RACE _____ MARITAL STATUS _____
EMPLOYER _____ OCCUPATION _____
HOME # _____ CELL # _____ WORK # _____
HUSBANDS NAME _____ HIS SSN _____
FAMILY PHYSICIAN _____ PHONE # _____
EMERGENCY: NAME _____ **PHONE #** _____ **RELATIONSHIP** _____
CONTACT

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____
POLICY/ID NUMBER _____ GROUP/PLAN # _____
RELATIONSHIP TO INSURED: SELF () SPOUSE () CHILD () OTHER () _____
NAME OF INSURED/RESPONSIBLE PARTY _____
INSURED'S DATE OF BIRTH _____ INSURED'S SSN _____ SEX _____
ADDRESS (IF DIFFERENT) _____ CITY _____ ST _____ ZIP _____
INSURED'S EMPLOYER _____ PHONE # _____

SECONDARY INSURANCE COMPANY _____
POLICY/ID NUMBER _____ GROUP/PLAN # _____
RELATIONSHIP TO INSURED: SELF () SPOUSE () CHILD () OTHER () _____
NAME OF INSURED/RESPONSIBLE PARTY _____
INSURED'S DATE OF BIRTH _____ INSURED'S SSN _____ SEX _____
ADDRESS (IF DIFFERENT) _____ CITY _____ ST _____ ZIP _____
INSURED'S EMPLOYER _____ PHONE # _____

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health to: THE OFFICE. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs or collection. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment.

SIGNED _____ **DATE** _____