PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____ REFERRED BY:_____ SEX:_____

NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____ CELL PHONE:_____ WORK NUMBER:_____

SS #_____ MARITAL STATUS:_____ EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

****

NEXT OF KIN:_____ BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____ BIRTHDATE_____ TELEPHONE:_____

****

PRIMARY INSURANCE:_____ ID#:_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ ID#_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____ DATE:_____

MEDICATION SUMMARY

PATIENT _____ DOB _____/_____/_____

PHARMACY _____PHARMACY PHONE # _____

ALLERGIES _____

_____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY