



Personal Information

Today's Date: Account#: SSN:
First Name: MI: Last Name:
Address:
City: State: Zip Code:
Date of Birth: Age: Marital Status:
Sex: Male Female May we leave information on your answering machine or voicemail? Yes No
Primary Phone: (number you wish to be reached at) Other #:
Employer: Occupation:
Work #: Full Time Student: Yes No

In the event of an emergency, please contact:

Name: Relationship: Phone #:
Minor Patients: Name of Parent/Guardian:
Who Referred You? Physician Family Friend Phone Book Insurance Co. Other
Referring Physician's Name: Phone #:
Address:

Insurance Information

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: Insured's Name:
Patient's Relationship to Insured: Self Spouse Child Other
Policy #: Group #:
Employer: SSN: DOB:
Secondary Insurance: Insured's Name:
Patient's Relationship to Insured: Self Spouse Child Other
Policy #: Group #:
Employer: SSN: DOB:

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide this information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: Date: