



PATIENT INFORMATION FORM (Please Print Clearly)

Date: _____

PATIENT'S NAME		SOCIAL SECURITY #		BIRTHDATE		AGE		
STREET ADDRESS			CITY AND STATE		ZIP CODE		HOME PHONE #	
HOME PHONE #			EMAIL ADDRESS					
REFERRED BY:			MARITAL STATUS		DRIVER'S LICENSE #		WORK PHONE #	
PATIENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)			CELL PHONE #		
EMPLOYER'S ADDRESS			CITY AND STATE			ZIP CODE		
HERE TO SEE WHICH PROVIDER:								
SPOUSE (OR GUARDIAN'S) NAME: OTHER THAN SPOUSE								
1. EMERGENCY CONTACT: (OTHER THAN SPOUSE)				RELATIONSHIP		PHONE #		
2. EMERGENCY CONTACT: (OTHER THAN SPOUSE)				RELATIONSHIP		PHONE #		

We require all patients to show their insurance or managed care membership card, and their driver's license, so that we may make copies for our permanent record.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemization to assist in making collections from insurance companies and will credit any such collections to the patient's account.

***** PAYMENT AND RELEASE OF INFORMATION AUTHORIZATION *****

I, _____ hereby authorize the Doctor's Office, LLC to furnish information concerning my present illness. I direct the insurer to pay without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and/or attorney fees associated with my failure to pay my debt. A facsimile of this authorization will be as valid as the original.

I understand that if I fail to keep a scheduled appointment I will be responsible for a \$25 fee.

I hereby authorize the Doctor's Office LLC to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary.

A 1.5% late fee is due and payable on all patient due balances greater than 30 days past due.

SIGNATURE OF PATIENT (GUARDIAN)

DATE: