

PATIENT INFORMATION FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_ Race: \_\_\_\_\_ Alias: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cty: \_\_\_\_\_  
Phone-home: \_\_\_\_\_ Phone-work: \_\_\_\_\_  
Phone-cell: \_\_\_\_\_ Phone-other: \_\_\_\_\_  
Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date-of-Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Alerts: \_\_\_\_\_ Advance Directives, Living Will, or POW: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Remarks: \_\_\_\_\_

Plan Information:

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Insured: \_\_\_\_\_ Insured Date-of-Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Plan Information:

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Insured: \_\_\_\_\_ Insured Date-of-Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Employer:

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Allergies: \_\_\_\_\_

Is this visit work related or MVA? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, when did it occur? \_\_\_\_\_

\_\_\_\_\_ I have insurance and understand that I am financially responsible for all charges not covered by my insurance. I request that payment of authorized benefits be made wither to me or on behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services.

\_\_\_\_\_ I do not have insurance coverage and understand that I am financially responsible for all charges. I understand that payment is due at the time of service.

Date: \_\_\_\_\_ Signature/Parent: \_\_\_\_\_