

PATIENT INFORMATION SUMMARY

Personal Information

Name: _____ Age: _____ Birth date: _____

Address: _____ City: _____ Zip: _____

Phone: Home: _____ Work: _____ OK to leave message _____

Place of Employment: _____

Social Security Number: _____ E-mail: _____

Emergency Contact: Name: _____ Phone: _____

Insurance Company

Insurance Company: _____ Is preauthorization needed? _____

Policy Number: _____ Group Number: _____ Co-pay: \$ _____

Please note: If preauthorization is required by your insurance company(s) and has not been done, you will be responsible for payment in full of your initial visit and subsequent visits.

If you are not the policy holder, please complete the following:

Name of Policy Holder: _____ Relationship to Policy Holder: _____

Address of Policy Holder: _____ City: _____ Zip: _____

Birth date of Policy Holder: _____ SSN of Policy Holder: _____

Place of employment of Policy Holder: _____

Name of Additional Insurance (if applicable): _____

*Do we have your permission to discuss financial matters with the policy holder above: _____

Responsible Party: If you wish to have your bills sent to someone other than yourself, please indicate below. *If patient is a minor, this section MUST be completed!*

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Social Security Number: _____ Employer: _____

If we are unable to keep our appointment with you, we will let you know immediately. Please afford us the same consideration by giving 24 hours notice if you must cancel your appointment. We will charge for an office visit for all appointments not canceled in a timely manner.

PLEASE READ and sign below:

I certify the above information is correct, and I consent to the release of information necessary to process insurance claims. We will release information only to the insurance companies listed above. If your insurance changes, please notify us immediately. I agree to pay all remaining balances upon receipt.

Signature of patient or guardian

Date