PATIENT ACCOUNT INFORMATION

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PATIENT

Patient Full Legal Name _____
Last First M.I.

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____ Date of Birth _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner Physician _____

Employer Name _____ Social Security # _____

Employer Address _____ Email _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell ☐ OK to leave message

RESPONSIBLE PARTY

Check here if same as patient and skip to insurance information: ☐

Name _____
Last First M.I.

Address _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ PPO ☐ Private ☐

Insurance Address _____ City _____ State ____ Zip Code _____

Name of Insured _____ ☐ Male ☐ Female

Insured Date of Birth _____ Insurance I.D. # _____ Group # _____

Insured Employer Name _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ PPO ☐ Private ☐

Insurance Address _____ City _____ State ____ Zip Code _____

Name of Insured _____ ☐ Male ☐ Female

Insured Date of Birth _____ Insurance I.D. # _____ Group # _____

Insured Employer Name _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT INFORMATION

Name of Person to Contact _____ PPO ☐ Private ☐

Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Work Phone _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for services rendered. I hereby attest that the above insurance information accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the Insurance Company and that insurance is an agreement between me and my insurance company. If there are problems collecting payment, attorneys fees, collection agency costs and any related fees will be added to the bill. I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat and test.

Patient's Signature: _____ Date_____