PATIENT INFORMATION FORM

Account ______________________ Date ______________

Patient

Last name ______________ First name ______________ Middle ______________

Street address ______________________ Apt. # ______________

City ______________ State ______________ Zip ______________

Home phone (_____) ______________ Work phone (_____) ______________ Cell phone (_____) ______________

Date of birth ______________ Last 4 digits SS# ______________ Age ______________ Sex M F

Driver's license # ______________________ Marital status ______________

Email ____

Employer ______________________ Employer Phone # ______________

Employer address ______________________ City ______________ State ______________

Spouse's name ______________________ Spouse's employer ______________

Employer address ______________________ Employer phone # ______________

Friend or relative not living with you ______________ Phone # (____) ______________

Pharmacy name ______________________ Phone # ______________

How did you hear about our office ?

- ☐ Family/friend
- ☐ Family Doctor
- ☐ Internet/Google
- ☐ Billboard
- ☐ Insurance referral

Insurance Information

Primary Insurance Co. ______________________ Policyholder Name ______________

Policyholder Birthdate ______________

Second Insurance Co. ______________________ Policyholder Name ______________

Policyholder Birthdate ______________

Guarantor Information (for minor children only)

Name ______________________ Street address ______________________

City ______________________ State ______________ Zip ______________

Home phone ( ) ______________ Relationship to patient ______________ Occupation ______________

Have you had any recent testing (MRI, CT scan, etc.) for head or neck. If possible, please bring copy of report.

Yes ________ **No** ________ **If yes, where and when** ______________________

I understand, acknowledge, and agree that I am responsible for payment of any health care services provided to the extent not covered by my health insurance, for the reason I did not have a referral (authorization) from my primary care physician.

I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

Your signature below indicates your consent for treatment of/as patient and responsibility for paying the bill.

I hereby authorize the payment of medical benefits directly to the physician.

SIGNATURE ______________________________________ DATE ______________

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