PATIENT INFORMATION

LAST NAME: _____ FIRST: _____MI: _____ DOB: _____/_____/_____ SEX: M____F____

STREET: _____APT #: _____ CITY: _____ STATE: _____ ZIP: _____

SS #_____ H. PHONE: _____ WK PHONE: _____CELL PHONE: _____

MARRIED ____ SINGLE_____DIVORCED_____ OTHER_____ SPOUSE'S NAME: _____ SPOUSE'S PHONE #_____

EMAIL ADDRESS: _____ REFERED TO THIS OFFICE BY: _____

EMERGENCY CONTACT NOT LIVING WITH YOU: _____ PHONE #: _____

PREFERED LANGUAGE _____ ETHNICITY/RACE: HISPANIC/LATINO _____ AMERICAN INDIAN OR ALASKIAN NATIVE _____

ASIAN _____ WHITE _____ BLACK/AFRICAN AMERICAN _____ NATIVE HAWIAIIAN/PACIFIC ISLANDER _____ OTHER_____ DECLINE TO SPECIFY_____

PRIMARY INSURANCE INFORMATION

(INSURED; IF PRIMARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARRENT OR OTHER INFORMATION OR PRIMARY INSURED BELOW)

INSURED NAME: _____ DOB: _____/_____/_____ SS#_____ SEX: M_____ F_____

INSURANCE COMPANY: _____ ID# _____ GROUP # _____

PATIENT'S RELATIONSHIP TO INSURED _____

SECONDARY INSURANCE INFORMATION

(INSURED; IF PRIMARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARRENT OR OTHER INFORMATION OR PRIMARY INSURED BELOW)

INSURED NAME: _____ DOB: _____/_____/_____ SS#_____ SEX: M_____ F_____

INSURANCE COMPANY: _____ ID# _____ GROUP # _____

PATIENT'S RELATIONSHIP TO INSURED _____

PAYMENT POLICY

YOU ARE RESPONSIBLE FOR ANYTHING YOUR INSURANCE DOES NOT COVER. ALL COPAYS ARE DUE AND PAYABLE AT EACH VISIT. THESE FEES MAY APPLY:

- $5 FEE FOR COPAY NOT PAID AT TIME OF SERVICE
- $50 FEE FOR ANY MISSED APPOINTMENT THAT WAS NOT CANCELLED OR RESCHEDULED 24 HOURS PRIOR TO THE APPOINTMENT.
- $35 NSF CHARGE FOR ANY RETURED CHECK FROM THE BANK

IF YOU ARE A PRIVATE PAY PATIENT WITHOUT INSURANCE, ALL CHARGES ARE DUE AT TIME OF VISIT. WE DO NOT SEND STATEMENT TO PRIVATE PAY PATIENTS.

PLASE SIGN AND DATE THIS DOCUMENT SHOWING THAT YOU HAVE READ AND UNDERSTOOD OUR POLICIES

SIGNITURE: _____ DATE: _____