WELCOME TO OUR OFFICE

About You

Today's Date: ____________

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: __________ ◻ Male ◻ Female Birth date: __________ Age: _____
SS#: ______________

Mailing Address: ____
CITY STATE ZIP

Home Phone #: __________ Work Phone #: __________ Cell Phone #: __________
Email Address: ______________ Referred By: ______________
Employer: ______________ How Long?: __________
Employer's Address: ______________ Occupation: ______________
____
CITY STATE ZIP
Status: ◻ Minor ◻ Single ◻ Married ◻ Divorced ◻ Separated ◻ Widowed
Spouse's Name: ______________________
Do You Have Children? ◻ Yes ◻ No How Many? _______

Account Information (Person ultimately responsible for account)

◻ Check if information is same as above
Name: ______________________
Relation: ______________________
Billing Address: ______________________
____
CITY STATE ZIP
SS#: ______________________
Drivers License #: ______________________
Work Phone #: ______________________
Payment Method: ◻ Cash ◻ Check ◻ Credit Card

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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INITIALS

IN EVENT OF EMERGENCY

Whom should we contact?: ______________________ Relation: ____________
Home Phone #: ______________ Work Phone #: ______________
Cell Phone #: ______________
Who is your Medical Doctor?: ______________________ Phone #: ____________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ______________________________ Date: ______________