PATIENT INFORMATION SHEET

DATE

REFERRED BY:___________________________

Name of Patient____ Marital Status: (circle) S M D W P
Last First MI

Address: ____E-Mail:____

City: _____________________________________STATE:____________________ZIP CODE:_______________________

Home Telephone: _______________CELL____________________ Work Telephone: _________________________________

Patient's Date of Birth: _________________ Patient's Sex: Male Female Patient's SSN ______-______-_______

Employer:____________________________________ Occupation: ______________________________________

Spouse's Name_________________________________ Spouse's SSN ______-_____-________

Spouse's Employer__________________________ Occupation: _________________________ Work Telephone: ____________

PERSON TO CALL IN CASE OF EMERGENCY

Name	Address	Phone	Relationship

Although services may be covered by insurance, I understand that I am fully responsible for payment for the care I receive. I understand an administrative service charge of 1% or $1.50 per month, whichever is greater, will be charged on all unpaid balances. I authorize payment of medical benefits to my practitioner for services rendered. I authorize the practitioner or insurance to release any information required for services rendered by this office. **I further understand there is a 24 hour cancellation policy and I will be billed if I fail to give the requisite notice. This fee is currently $100.00 and not covered by insurance.**

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Typed Signature Date

WE WILL NEED A COPY OF YOUR INSURANCE CARDS AND PHOTO ID

INSURANCE

PATIENT INSURANCE (PRIMARY)		ADDITIONAL INSURANCE (SECONDARY)	
NAME OF INSURED	RELATION TO PATIENT	NAME OF INSURED	RELATION TO PATIENT
BIRTHDATE	EMPLOYER	BIRTHDATE	EMPLOYER
INSURANCE COMPANY		INSURANCE COMPANY	
ID/SS NUMBER	GROUP NUMBER	ID/SS NUMBER	GROUP NUMBER