*For Internal Use Only*
*PT ID Number*

## Patient Information

Social Security # _____ Birth Date _____

Last Name _____ First Name _____ M.I. _____ Maiden or Nickname _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone # (____) ____ – _____ Work Phone # (____) ____ – _____ Ext. ____ E-Mail Address _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

## Patient's Employer Information

Employer's Name _____ Patient's Occupation _____

Address _____ If Student: ☐ Full time ☐ Part time

City _____ State _____ Zip _____

## Insurance Information - Primary / Secondary / Other

*****Please Give Your Insurance Cards To The Receptionist*****

Do you have health insurance? Yes / No (Please circle one)

**Primary Insurance Company Name** _____

Please indicate the policyholder for the primary insurance: ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

**Secondary Insurance Company Name** _____

Please indicate the policyholder for the secondary insurance: ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

## Spouse's Information Or Parent's Information (If Patient is covered by Parent's Insurance)

Spouse's or Parent's Name _____ Spouse's or Parent's Birth Date _____

Spouse's or Parent's SS# _____ Employer's Phone # (____) ____ - _____

Spouse's or Parent's Employer _____

Spouse's or Parent's Employer's Address _____

City _____ State _____ Zip _____

## Emergency Information

*Please list the nearest living relative/friend other than your spouse/parent.*

In case of an emergency, we may contact:

_____

(____) - _____ _____

Telephone No. Relationship to Patient

## Other

Primary Care Physician's Name:

_____

Primary Physician Name in This Office:

_____

## How Did You Find Out About Us?

☐ From a current patient? (CP)
Name: _____
☐ Advertising (AD) ☐ Yellow Pages (YP)
☐ Internet (IT)
☐ Referral by Physician (RP)
Name: _____
☐ Health Plan/Insurance Directory (INS)

## Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to the _____ _____, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed, I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the _____, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____

Signature of Patient or Parent of Minor Date

## Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to

_____

for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Patient's Signature Date