PATIENT INFORMATION FORM

WELCOME TO OUR OFFICE

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TODAY'S DATE_____

REFERRED BY_____

IN ORDER TO SERVE YOU PROPERLY,
WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

(PLEASE PRINT CLEARLY)

GENERAL

PATIENT'S NAME_____ BIRTHDATE_____
(Last) (First) (Middle) (Nickname) (Month, Date, Year)

MARITAL STATUS_____ E-MAIL_____

ADDRESS_____

HOME PHONE (Area Code)_____ WORK PHONE (Area Code)_____ CELL PHONE (Area Code)_____

EMPLOYER_____ ADDRESS_____

NAME OF SPOUSE (OR PARENT / GUARDIAN)_____ ADDRESS_____

SS#/SIN OF SPOUSE (OR PARENT / GUARDIAN)_____ PHONE (Area Code)_____

MEDICAL

CHIEF COMPLAINT / REASON FOR VISIT_____

DATE OF LAST GENERAL PHYSICAL EXAM (Month – Year)_____

LIST ANY ALLERGIES YOU HAVE (DRUGS, FOOD, OTHER)_____

LIST ANY MEDICATIONS YOU ARE TAKING_____

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT_____

DO YOU HAVE HIGH BLOOD PRESSURE?_____ DIABETES?_____

DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?_____

_____

_____

INSURANCE

PRIMARY INSURANCE COMPANY_____ POLICY #_____

INSURED NAME_____ SS#/SIN_____

DO YOU HAVE INSURANCE THROUGH YOUR EMPLOYER?_____ IF YES, I.D. #_____

GROUP #_____

ANY SECONDARY INSURANCE?_____ IFYES, COMPANY_____

ADDRESS TO SEND CLAIM_____

_____

_____

FINANCIAL

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER POSSIBLE INSURANCE BENEFITS.

Signed_____ Date_____
(Patient, or Parent / Guardian if Minor)

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the names provided for professional services rendered.

Signed_____ Date_____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Signed_____ Date_____
(Patient, or Parent / Guardian if Minor)

Thank You For Choosing Our Office!