Confidential Patient Information

Today's Date: ____________________

Name:___________________________________ ____ ___/___/___

(Last) (First) (Sex) (Date of birth)

Perm. Address: ______________________________ City: ______________ State: ____ Zip: _________

Phone Perm: ________________ Cell Phone: ________________ Phone Work: _________________

Driver's License #: _____________________ State: ______ Email Address: ____________________

How did you hear of us?

Yellow Pages:_______ Newspaper:______ Radio/TV:________ Internet:_______ Sign:_______

Were you referred by another physician: ☐ Yes ☐ No

Referring Physician's Name: _________________________________ Phone: ____________________

Address, City, State, Zip: ____

Who is your current Physician: _______________________________ Phone: ____________________

Employer: __________________________ Occupation:_________________ Phone: ____________

Perm. Address: ______________________________ City: ______________ State: ____ Zip: _________

Nearest relative not living with you: _____________________Relation: ________ Phone:____________

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Name of Spouse (or parent for minor child): ______________________

Emergency Contact: _________________ Relationship to you: ________ Phone: ______________

Insurance Company: ____ Phone: __________________

Name of Insured: _______________________________ Relationship to the Insured: ________________

S.S. #: _____/_____/_____ Policy #: _______________________ Group #: _____________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Copy front and back of insurance card and attach to this form.

_________________________ _________________________ ____________

Patient's Signature **Parent or Guardian's Signature** **Date**

_________________________ _________________________

Please Print Name **Please Print Name**