PATIENT INFORMATION FORM

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PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE) ☐ MR ☐ MRS ☐ MISS	DATE OF BIRTH / /	AGE	MARITAL STATUS ☐ S ☐ M	TODAY'S DATE / /
ADDRESS (STREET, CITY, STATE, ZIP)	HOME PHONE ( )			
NAME OF EMPLOYER	OCCUPATION	HOME PHONE ( )	EXTENSION	
EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP)	SOCIAL SECURITY NO.			
SPOUSE'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH / /	NAME OF EMPLOYER	WORK PHONE ( )	
NEAREST FRIEND NOT LIVING WITH YOU	PHONE NO. ( )	NEAREST FRIEND NOT LIVING WITH YOU	PHONE NO. ( )	
IN CASE OF EMERGENCY CONTACT NAME:	RELATIONSHIP	PHONE NO. ( )		
WHO MAY WE THANK FOR REFERRING YOU TO US?	FAMILY PHYSICIAN	PHONE NO. ( )	FAMILY DENTIST	PHONE NO. ( )
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?	I WILL BE PAYING TODAY BY ☐ CASH ☐ CHECK ☐ CREDIT CARD			

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET, CITY, STATE, ZIP)		PHONE NO. ( )
NAME OF INSURED	RELATIONSHIP	I. D. NO.	GROUP NO.
SECONDARY INSURANCE NAME	ADDRESS (STREET, CITY, STATE, ZIP)		PHONE NO. ( )
NAME OF INSURED	RELATIONSHIP	I. D. NO.	GROUP NO.

PAYMENT POLICY

Payment for routine care is expected at time of service. At this time, we will submit your insurance for you. Reimbursement for covered benefits will be paid directly to you. For more extensive treatment, financial arrangements will be made with the business office.

Please feel free to discuss financial arrangements or billing matters with our office at any time