

Please Complete All Portions

Today's Date: _____

Patient's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____

Business Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Sex: _____

Patient's Social Security Number: _____

Marital Status: Single Married Divorced Widowed Separated

Person Responsible for Payment: _____ SS#: _____

Relationship to Patient: _____

Address (if different than above): _____ Phone: _____

Occupation of Responsible Party: _____ Employer: _____ Phone: _____

Spouse's Name: _____ Employer: _____ Phone: _____

Local Friend or Relative to Contact in Case of Emergency

Name: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

HIPAA POLICIES

PLEASE answer the following by circling YES or NO:

Do you give our office permission to leave messages at home regarding test results as well as appointments? YES NO

With family members? YES NO _____

With friends or others? YES NO _____

Authorization of pay benefits to physician: I hereby authorize payment to be made directly to my physician for medical and/or surgical benefits, if any, otherwise payable to me for his services and all future claims. A copy of this authorization shall be as valid as the original. I also hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

Signature: _____ Date: _____