Patient Information

Patient Information

Patient Name: ______________________ DOB: ______________ Sex: ________

Driver's License: ______________________ SSN: ______________________

Home Phone: ______________________ Cell: ______________________

Address: ____

Employer: ______________________ Position: ______________________

Employer Address: ______________________ Phone No. ______________________

Emergency Contact Information

Dependent? ____________ If yes, Guardian's Name: ______________________

Guardian's Phone: ______________________ Cell: ______________________

Marital Status: ______________________ Spouse's Name: ______________________

Spouse's Employer: ______________________ Work Phone No. ______________________

Emergency Contact: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell: ______________________

Insurance

Insured Party: ______________________ Relationship to Patient: ______________________

Insurance Company: ______________________ Phone No. ______________________

Address: ____

Policy No. ______________________ Group No. ______________________

Dual Coverage? ________ 2nd Insurance Company: ______________________

Insured Party: ______________________ Relationship to Patient: ______________________

Phone No. ______________________ Address: ______________________

Policy No. ______________________ Group No. ______________________

Payment Method: ______________________ Card/Check No. ______________________

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

______________________________ ______________________

Patient Date