

# PATIENT INFORMATION SHEET

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
EMAIL Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Sex: M  F  Race: Caucasian  African American  Hispanic  Other   
Hair Color: Brown  Black  Gray  Blonde  Auburn   
Employed: yes  no  FT Student: yes  no  Marital Status: \_\_\_\_\_  
Employer/School: \_\_\_\_\_  
Family Physician: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
If Under 18, name of responsible party: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

## INSURANCE COMPANY

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_  
ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_  
ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

### **Fees For Professional Services Are Due At The Time Services Are Rendered.**

ASSIGNMENT & FINANCIAL REPONSIBILITY: I hereby assign my insurance benefits to be paid directly to my Doctor. I am responsible for all charges, whether or not paid by insurance. In the event that it becomes necessary for this account to be turned over to an attorney or agency for collection the undersigned agrees to pay all fees and costs associated with such action.

\_\_\_\_\_  
Patient Signature (Guardian if Minor)

\_\_\_\_\_  
Date

Responsible Party Name: \_\_\_\_\_ SS#: \_\_\_\_\_ PH #: \_\_\_\_\_