

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status: S M W D Your SS# _____

Email Address _____

Your Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ Your SS# _____ Driv Lic# _____

May we call you at work? Yes ___ No ___ Do you have health insurance where you work? Yes ___ No ___

What is your relationship to the primary insurance holder? Self ___ Spouse ___ Child ___ Other _____

Insurance Company _____ Plan/Group # _____

Complete if spouse or parent is the primary insurance holder or for a child under 18.

Name of Spouse or Parent _____ Birth Date _____

Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ SS# _____ Driv Lic # _____

Describe your health concern or reason that brings you to our office _____

Is your condition due to an accident? Yes ___ No ___ Date of Accident _____

Type of accident? Auto ___ Work/On Job ___ At Home ___ Other _____

Have you ever been in an Auto Accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never ___

Notice to our New Patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance, the deductible must be met in the beginning unless prior arrangements are made.

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I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and me and that I am personally responsible for payment of any and all services covered or non-covered. 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.

Patient Signature _____ Date _____

Spouse or Guardians Signature _____ Date _____

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HEALTH QUESTIONNAIRE

Name: _____

Date: _____

List all your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatment?
When?

Please check the conditions you have or have had:

AIDS or HIV+

Anemia

Arthritis

Cancer

Epilepsy

Hypoglycemia

Multiple Sclerosis

Parkinson's Disease

Polio

Rheumatic Fever

Tuberculosis

Venereal Disease

AUTHORIZATION AND RELEASE

Patient's Name

Date

Authorization to Release Information

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

Signature

Witness

Date

Authorization to Pay Doctor/Clinic

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

Signature

Witness

Date

Affidavit of Primary Insurance for Dependent

Insurance Co.: _____ Policy/ID No. _____.

Please be advised that I am the _____ for the dependent patient named above, and that the above named insurance company is his/her PRIMARY COMPANY as there is no other insurance at this time.

This is to further advise that this patient IS a full-time student __ ; IS NOT a full time student __.

Parent/Guardian Signature

Witness

Date