Patient Information

Welcome to our office. Please complete this form and return it to our receptionist.

Name_____ Email_____

Address_____ City _____State_____ Zip_____

Date of Birth_____ Age_____ Male/Female_____ Social Security #_____

Telephone_____ Mobile_____ Work_____

Occupation_____Employer_____

Work Address_____

Married/Single_____ Name of Spouse_____ Telephone_____

Spouse's Employer_____

Spouse's Work Address_____

For patients under 18 years of age name of Parent/Guardian_____

Guardian's Employer_____

Primary Care Doctor_____

Referring Doctor_____

Primary Insurance Carrier_____

Policy Holder's Name_____D.O.B._____

Secondary Insurance Carrier_____

Policy Holder's Name_____D.O.B._____

Vision Plan_____

Policy Holder's Name_____D.O.B._____

Emergency Contact_____ Telephone_____

Authorization to release information
I hereby authorize the above doctor to furnish the insured's insurance company all the information which said insurance company may request concerning my claim.
Assignment of insurance benefits
I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. I understand that I am financially responsible to said doctor for charges.

_____ _____ _____

Responsible Party's Signature **Patient's Signature** **Date**