APPOINTMENT DATE ____________ TIME ____________

PATIENT INFORMATION

____ Mr./Mrs./Miss/Ms.
Last Name First Name Middle Name

Mailing Address ____
Street City State Zip

E-Mail Address ________________ Cell Phone ______________ Pager ____________

Home Phone (_____) ________________ Work Phone (_____) ________________

Sex M / F Birthdate ____/____/____ SS# ________________

Employer: ____

________________________________ Occupation: ________________

Employer Address: ____

Is Patient Allergic to any Medications? Y / N LIST ________________________

Health History ____
(High Blood Pressure, Rheumatic Fever, Diabetes, Etc.,)

INSURANCE / POLICY HOLDER INFORMATION

____ Mr./Mrs./Miss/Ms.
Last Name First Name Middle Name

Mailing Address ____
Street City State Zip

Home Phone (_____) ________________ Work Phone (_____) ________________

Social Security No. ________________ Drivers License No. ________________

Sex M / F Birthdate ____/____/____

Employer: ____

________________________________ Occupation ________________

Employer Address: ____

Insurance Company #1 ____

Insurance Company #1 Address ____

Policy Holder ______________ SS# ______________ Group Policy# ____________

Insurance Company #2 ____

Insurance Company #2 Address ____

Policy Holder ______________ SS# ______________ Group Policy# ____________

Who were you referred by? ____

Whom may we thank? ____

ADDRESS AND PHONE NUMBER OF A RELATIVE OR FRIEND:

Name: ________________________________ Phone: ________________

Address: ____
Street City State Zip

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician or insurance benefits under which I am entitled.

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved.

I fully understand, that if for any reason an insurance claim is denied benefits after the treatment is completed, I will then be responsible for the balance of the account.

________________________________ ________________________________
Signature of Patient Signature of Responsible Party