PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE

Please print clearly and have your insurance cards available when this form is completed

PATIENT INFORMATION

Date of Appointment _____ / _____ / _____

Name _____ Age_____ Date of Birth_____/_____/_____
Last First Middle

Address _____
Street City State Zip Code

Ethnicity (optional) : ___African American ___Asian ___Caucasian ___Native American ___Pacific Islander ___Other ___ Decline to specify

Marital Status: **M S W D** Sex: **M F** _____

PHONE NUMBERS (Please check the number where you can be reached during the day):

❑ Home: (_____) _____ ❑ Work: (_____) _____ ❑ Cell: (_____) _____

Patient's Employer:_____

Referred by_____ Patient's Physician _____

Physician Phone# (_____) _____

DO YOU HAVE ANY KNOWN DRUG / MEDICATION ALLERGIES ? ❑ No ❑ Yes If yes, list all drug allergies below:

DO YOU REQUIRE ANTIBIOTIC PROPHYLAXIS WHEN UNDERGOING SURGICAL PROCEDURES, SUCH AS HAVING DENTAL WORK?

❑ No ❑ Yes If yes, why: Pharmacy Name:_____

Phone or Location_____

INFORMATION ON PERSON RESPONSIBLE FOR PATIENT

❑ Self ❑ Spouse ❑ Parent

❑ Legal Guardian (Relationship) _____

Name _____
Last First Middle

If Child: Birth Date of Both Parents: ____ / ____ / ____ ____ / ____ / ____
Mother Father

If Spouse: Birth Date: ____ / ____ / ____
Spouse

Address and Phone Number, if Different than Above:_____

Employer and Phone Number:_____

INSURANCE INFORMATION

1) _____
#1 Insurance Company Name Subscriber

I.D. # _____ Group#_____ Plan or Code_____

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Parent, Legal Guardian

2) _____
#2 Insurance Company Name Subscriber

I.D. # _____ Group#_____ Plan or Code_____

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Parent, Legal Guardian

1) I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN FOR SERVICES RENDERED.
2) I AUTHORIZE RELEASE OF MEDICAL INFORMATION RELATIVE TO TREATMENT
3) I UNDERSTAND AND ACKNOWLEDGE THAT:
A) ANY BILLABLE SERVICES NOT COVERED BY MY INSURANCE, WILL BE MY FINANCIAL RESPONSIBILITY.
B) I WILL BE CHARGED A FEE (NOT COVERED BY INSURANCE) FOR CANCELLATION OF AN APPOINTMENT, UNLESS 24 HOURS NOTICE HAS BEEN GIVEN.

_____ _____ / _____ / _____
Signature of Insured Authorized Person Date