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 _____ Social Security # _____
Last First Middle

Address _____
Street City State Zip Code

Date of Birth ___ / ___ / ___ Age _____ 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:

INFORMATION ON PERSON RESPONSIBLE FOR PATIENT

☐ Self ☐ Spouse ☐ Parent

☐ Legal Guardian (Relationship) _____

NAME _____ Social Security # _____
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 or Authorized Person Date

12/11/2006