"Making Individuals' Lives Better"

Patient Information

Patient Information

Patient Name:_____

DOB:_____**Sex:**_____

Driver's License:_____ SSN:_____

Home Phone:_____ **Cell:**_____

Address:_____

Employer:_____ Position:_____

Employer Address:_____ Phone No._____

Emergency Contact Information:

Dependent?_____ If yes, Guardian's Name:_____

Guardian's Phone:_____ Cell:_____

Marital Status:_____ Spouse's Name:_____

Spouse's Employer:_____ Work Phone No._____

Emergency Contact:_____

Relationship:_____

Home Phone:_____ Cell:_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cell:_____

Insurance

"Making Individuals' Lives Better"

Insured Party:_____ Relationship to Patient:_____

Insurance Company:_____ Phone No._____

Address:_____

Policy No._____ **Group No._____**

Dual Coverage?_____ 2nd Insurance Company:_____

Insured Party:_____ Relationship to Patient:_____

Phone No._____

Address:_____

Policy No._____ Group No._____

Payment Method:_____ Card/Check No._____

I Verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays,photographs,anesthetics,medicines,surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize Kirstin Care, LLC to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Date