# PATIENT INFORMATION

*******THIS IS A 2 PAGE FORM*******

PATIENT NAME_____ BIRTHDATE_____SEX_____

ADDRESS_____ CITY_____ STATE____ ZIP_____

PRIMARY PHONE_____ **[ ] CHECK IF OK TO TEXT**

**SIBLINGS** NAME_____ AGE_____NAME_____ AGE_____

NAME_____AGE_____NAME_____ AGE_____

# PARENTAL INFORMATION

MOTHER'S NAME_____ BIRTHDATE_____SS#_____

HOME PHONE_____ CELL PHONE_____

ADDRESS_____ CITY_____ STATE____ ZIP_____

WORK PHONE_____ EMPLOYER_____

Does parent live with child? Please circle one. YES NO

FATHER'S NAME_____ BIRTHDATE_____SS#_____

HOME PHONE_____ CELL PHONE_____

ADDRESS_____ CITY_____ STATE____ ZIP_____

WORK PHONE_____ EMPLOYER_____

Does parent live with child? Please circle one. YES NO

# PRIMARY INSURANCE INFORMATION

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S DOB_____ POLICY HOLDER'S ADDRESS_____

INSURANCE COMPANY_____ PHONE NUMBER_____

INSURANCE IDENTIFICATION NUMBER_____GROUP NUMBER_____

******* COMPLETE SIDE 2 (OVER) *******

# SECONDARY INSURANCE INFORMATION

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S DOB_____ POLICY HOLDER'S ADDRESS_____

INSURANCE COMPANY_____ PHONE NUMBER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE IDENTIFICATION NUMBER_____GROUP NUMBER_____

# EMAIL INFORMATION

Would you like to be contacted by E-Mail? Circle one. YES NO (Appointment reminders, etc.)

If so, please validate your E-Mail address. _____

# EMERGENCY CONTACT

NAME_____RELATIONSHIP TO PATIENT_____

PHONE #1_____ PHONE #2_____

**(SOMEONE OUTSIDE OF THE HOME)**

# CONSENT FOR TREATMENT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible and/or co-payment amount, and that I am financially responsible for all charges whether or not paid by insurance. The practice is authorized to use my medical information in its quality assurance and utilization review programs, and may disclose such information for medical research purposes.

SIGNATURE_____ DATE_____