

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Phone H- _____ C- _____

**IN THE EVENT THAT WE WOULD NEED TO RESCHEDULE YOUR APPOINTMENT
PLEASE PROVIDE US WITH THE BEST PHONE NUMBER TO REACH YOU.
THANKS!**

Sex M F Age _____ Birth date ____ - ____ - ____

Single Married Widowed Separated Divorced

Patient employed by _____ Work # _____

Emergency

Contact _____ **Phone** _____

❖ **Referring Physician:** _____ Phone # _____

INSURANCE INFORMATION

If the patient is not the holder of any of the insurances listed below, please provide the DOB for that person.

Primary Insurance _____ DOB of card holder _____

Secondary Insurance _____ DOB of card holder _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____