

PATIENT INFORMATION SHEET

DATE

REFERRED BY: _____

Name of Patient _____ Marital Status: (circle) S M D W P
Last First MI

Address: _____

City: _____ STATE _____ ZIP _____

Home Telephone: _____ CELL _____ Work Telephone: _____

Patient's Date of Birth: _____ Patient's Sex: Male Female Patient's SSN _____ - _____ - _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's SSN _____ - _____ - _____

Spouse's Employer _____ Occupation: _____ Work Telephone: _____

PERSON TO CALL IN CASE OF EMERGENCY
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Name	Address	Phone	Relationship

Although services may be covered by insurance, I understand that I am fully responsible for payment for the care I receive. I understand an administrative service charge of 1% or \$1.50 per month, whichever is greater, will be charged on all unpaid balances. I authorize payment of medical benefits to my practitioner for services rendered. I authorize the practitioner or insurance to release any information required for services rendered by this office. **I further understand there is a 24 hour cancellation policy and I will be billed if I fail to give the requisite notice. This fee is currently \$50.00 and not covered by insurance.**

Signature _____

Date _____

WE WILL NEED A COPY OF YOUR INSURANCE CARDS

INSURANCE	PATIENT INSURANCE (PRIMARY)		ADDITIONAL INSURANCE (SECONDARY)	
	NAME OF INSURED		NAME OF INSURED	
	RELATION TO PATIENT		RELATION TO PATIENT	
	BIRTHDATE	EMPLOYER	BIRTHDATE	EMPLOYER
	INSURANCE COMPANY		INSURANCE COMPANY	
ID/SS NUMBER	GROUP NUMBER	ID/SS NUMBER	GROUP NUMBER	