PATIENT ACCOUNT INFORMATION

PATIENT

Patient Name: _____ □ Male↑ □ Female
Last First M.I.
Address: _____
Street City State Zip Code
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Marital Status: □ Single □ Married □ Divorced □ Widowed Date of Birth: _____ / _____ / _____ DL or ID: _____

Patient Email Address: _____ Social Security Number : _____ - _____ - _____

Employer Name: _____ Occupation: _____

Employee Address: _____ Employer Phone: (_____) _____ - _____

SPOUSE OR GUARDIAN

Spouse or Guardian: _____ □ Male↑ □ Female
Last First M.I.
Address: _____
Street City State Zip Code
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Marital Status: □ Single □ Married □ Divorced □ Widowed Date of Birth: _____ / _____ / _____ DL or ID: _____

Patient Email Address: _____ Social Security Number : _____ - _____ - _____

Employer Name: _____ Occupation: _____

Employee Address: _____ Employer Phone: (_____) _____ - _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: _____ □ HMO □ Medicare □ PPO □ Private

Address: _____
Street City State Zip Code
Policy or Identification Number: _____ Effective Date: _____ / _____ / _____

Medicare Number: _____ Medical Number: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: _____ □ HMO □ Medicare □ PPO □ Private

Address: _____
Street City State Zip Code
Policy or Identification Number: _____ Effective Date: _____ / _____ / _____

Medicare Number: _____ Medical Number: _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits/coverage and tests ordered by my doctor may NOT be covered**. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that out charges will be paid by the Insurance Company. Insurance is an agreement between you and you insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's Signature: _____ Date: _____ / _____ / _____