PATIENT INFORMATION

DATE _____

LAST NAME_____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE_____ ZIP_____

HOME PHONE _____ WORK PHONE_____

CELL PHONE _____ E-MAIL _____

BIRTHDAY____/____/____ SOCIAL SECURITY # _____

MARITAL STATUS S M D W

SPOUSE'S NAME _____

PERSON RESPONSIBLE FOR BILL _____

ADDRESS_____ CITY _____ ZIP _____

YOUR SIGNATURE ON THIS FORM WILL SERVE AS OUR "SIGNATURE ON FILE" FOR INSURANCE FORMS_____

**IF YOU HAVE INSURANCE OUR OFFICE WILL BILL AND ACCEPT PAYMENT DIRECTLY FROM THEM IF THE SERVICES QUALIFY FOR COVERAGE. ANY CHARGES NOT COVERED ARE PAYABLE BY THE PATIENT. YOUR SIGNATURE HERE WILL SERVE AS YOUR AGREEMENT TO PAY FOR SERVICES AND MATERIALS NOT COVERED.

_____ DATE_____

WERE YOU REFERED TO OUR OFFICE? IF YES, BY WHOM?

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