



Patient Information Record

Please Print

Patient Name _____ Age _____ Gender M F
Home Phone _____ Cell Phone _____ DOB _____ SSN _____
Email Address _____ Marital Status S M W D Sep
Street Address _____
City _____ State _____ Zip _____

Employer _____ Occupation _____ How Long _____
Employer Address _____ Phone _____
City _____ State _____ Zip _____

Primary Doctor _____ Phone _____
Primary Doctor Address _____
City _____ State _____ Zip _____

Pharmacy _____ Cross Streets _____ Phone _____
Pharmacy Address _____
City _____ State _____ Zip _____

Referred by _____

Emergency Contact _____ Relationship _____
Street Address _____ Phone _____
City _____ State _____ Zip _____

Spouse (or Parent, if minor) _____
Date of Birth _____ SSN _____ Phone _____
Street Address _____
City _____ State _____ Zip _____

Employer _____ Occupation _____ How Long _____
Employer Address _____ Phone _____
City _____ State _____ Zip _____

Primary Insurance Company _____
Street Address _____ Phone _____
City _____ State _____ Zip _____

ID# _____ Policy# _____ Group# _____
Policyholder's Name _____ Relationship to Patient _____ DOB _____
Policyholder's Address _____ Phone _____
City _____ State _____ Zip _____
Policyholder's Employer _____ Phone _____
Street Address _____
City _____ State _____ Zip _____

Other Insurance Company _____
Street Address _____ Phone _____
City _____ State _____ Zip _____
ID# _____ Policy# _____ Group# _____
Policyholder's Name _____ Relationship to Patient _____ DOB _____
Policyholder's Address _____ Phone _____
City _____ State _____ Zip _____
Policyholder's Employer _____ Phone _____
Street Address _____
City _____ State _____ Zip _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Responsible Party Signature

Date