PATIENT INFORMATION

PLEASE PRINT

Chart Number ______________

Patient Information: Today's Date: ______________ Referred by: ______________

Patient Name ____
First *Middle* *Last* *Nickname*

Address ______________________ P.O./Apt # ______________

City ______________ State ________ County ________ Zip ________

Phone Number ______________ Patient Social Security Number ______________

Date of Birth Sex ☐ Male ☐ Female

Employer Name ______________ Employer Number ______________

Employer Address ____
City *State* *Zip*

Day Time Phone: ( ) ______________ Cellular Phone Number: ( ) ______________

Email Address: ______________ Pager Number: ( ) ______________

Race ______________ Ethnicity ______________ Primary Language ______________

Guardian Information:

Guardian Social Security Number ______________ Marital Status ______________

Guardian Date of Birth ______________ Relationship to Patient ______________

Emergency Contact: ***List most important first***

1)Name ______________ Phone Number ______________ Relationship ______________

2)Name ______________ Phone Number ______________ Relationship ______________

Billing Information: Responsible Party ***if other than patient***

Billing Name ____
First *Middle* *Last*

Address ____

City ______________ State ______________ Zip ______________ Phone Number ______________

Insurance Information: Please provide copies of all Medical Insurance and complete the following:

Primary Cardholder ____
First *Middle* *Last* *Insurance Company Name*

Address ______________________ Phone Number ______________

Insured's DOB ______________ Insured's Sex ☐ Male ☐ Female Social Security Number ______________

Employer Name/Address ____
Employer Phone Number

Secondary Cardholder ____
First *Middle* *Last* *Insurance Company Name*

Address ______________________ Phone Number ______________

Insured's DOB ______________ Insured's Sex ☐ Male ☐ Female Social Security Number ______________

Employer Name/Address ____
Employer Phone Number

"I certify the information given above by me is correct. I hereby authorize the release of any medical or other information to any third party payors to be used by them in consideration of payment of any claims resulting from my treatment. I will not hold this health care entity or its providers responsible for further dissemination of my medical information by the third party. I also authorize release of said information to and from my physicians, state or federal agencies, or other health care providers if needed for continuity of care, quality assurance or utilization review purposes. I authorize this facility, and such professional staff and aids it may designate to carry out such procedures, to administer treatment, and perform such care as indicated. I consent to the performance of those medical treatments and/or procedures in addition to or different from those now contemplated, that may arise from presently unforeseen conditions that may occur during my treatment. I further assign benefits to the physician and understand and agree that I am responsible for any balance due after insurance has been filed. A copy of this authorization may be used in place of the original."

Signature ______________________________ Date ______________