Welcome

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1. Personal Information

Date:_____

Birthdate;_____ Name:_____

Wishes to be called:_____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address:_____

City:_____ State:_____ Zip/PC: _____

E-mail:_____

Employer:_____ Occupation:_____

Referred by:_____

2. Responsible Party

Who is responsible for the account?

Name:_____

Relationship to patient:_____ Birthdate:_____

Address:_____

City:_____ State:_____ Zip/PC: _____

E-mail:_____

Employer:_____ Occupation:_____

Work Phone: _____ Ext#:_____

Home Phone:_____ Cell Phone:_____

3. Telephone

Employer:_____ Occupation:_____

Work Phone: _____ Ext#:_____

Home Phone:_____ Cell Phone:_____

Where do you prefer to receive calls: ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? ☐ Time ☐ Days

In the event of an emergency, who should we contact?

Name_____ Relationship_____ Work#_____ Home#_____

4. Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient or parent/guardian if minor Date

5. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment _____Cash _____Personal Check _____Credit Card:_____Visa _____MC _____I wish to discuss the office's payment policy.	**Late Charges** If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1/5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.