## **Patient Information Sheet**

## Welcome to our Office...

Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security#	E-mail
First Name:	Last Name:
Middle Initial:	Date of Birth: / Age:
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Other
Street Address:	City:
State: Zip:	Employer Name:
Home Phone: ( )	<b>Emergency Contact:</b>
Work Phone: ( )	Emergency Telephone#:
Cell Phone: ( )	Primary Care Physician:
Referring Doctor: Referring Dr.'s Address / City / State / Zip Ref. Dr. NPI #	
Patient's Insurance Information	
<b>Primary</b> Insurance Company Information:	Secondary Insurance Company Information:
PRIMARY INS. COMPANY INFORMATION	PRIMARY INS. COMPANY INFORMATION
Insurance's Name:	Insurance's Name:
Policy ID:	Policy ID:
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Group#	Group#
Group#	Group#
Group#  Policy Holder Information	Group#  Policy Holder Information
Policy Holder Information  First Name:	Policy Holder Information   First Name:
Policy Holder Information  First Name:  Last Name:	Policy Holder Information
Policy Holder Information  First Name:  Last Name:  Address:	Policy Holder Information
Policy Holder Information  First Name: Last Name: Address: City:State:Zip:	Policy Holder Information
Policy Holder Information  First Name:  Last Name:  Address:	Policy Holder Information
Policy Holder Information  First Name: Last Name: Address: City: State: Policy Holders SS#	Policy Holder Information
Policy Holder Information  First Name:	Policy Holder Information
Policy Holder Information  First Name:  Last Name:  Address:  City:  State:  Zip:  Policy Holders SS#  -  Policy Holders Date of Birth:  Gender:  Male  Female  Relationship to Policy Holder:  I hereby authorize the release of any medical inform the physician all payments for medical services remore courtesy that the doctor accepts my insurance for particular courtesy that the doctor accepts my insurance for particular payments in the properties of the properties of the properties of the properties of the payments for medical services removed including referrals, I among within 30 days are subject to a \$25 charge. After 60 will be responsible for all collection fees incurred.	Policy Holder Information  First Name: Last Name: Address: City: Policy Holders SS# Policy Holders Date of Birth: Gender: Male □ Female Relationship to Policy Holder: □Self □Spouse □Child □Other  mation necessary to process this claim and hereby assign to dered to my dependents or myself. I understand that it is a agment and that if for any reason my insurance does not responsible for payment. All balances not paid in full of days the account will be placed in collection and you is.
Policy Holder Information  First Name:  Last Name:  Address:  City:  Policy Holders SS#  Policy Holders Date of Birth:  Gender: □ Male  Relationship to Policy Holder: □ Self  □ Spouse  □ Child □ Other  I hereby authorize the release of any medical inform the physician all payments for medical services reme courtesy that the doctor accepts my insurance for pactorer services rendered, including referrals, I am within 30 days are subject to a \$25 charge. After 66 will be responsible for all collection fees incurred By signing below, I acknowledge that I have been supported to the support of the property of the physician all payments for medical services rendered, including referrals, I am a within 30 days are subject to a \$25 charge. After 66 will be responsible for all collection fees incurred.	Policy Holder Information  First Name: Last Name: Address: City: Policy Holders SS# Policy Holders Date of Birth: Gender:  Gende
Policy Holder Information  First Name:  Last Name:  Address:  City:  State:  Zip:  Policy Holders SS#   Policy Holders Date of Birth:  Gender: □ Male □ Female  Relationship to Policy Holder: □Self □Spouse  □Child □Other  I hereby authorize the release of any medical inform the physician all payments for medical services removed courtesy that the doctor accepts my insurance for payone the properties of the physician all payments for medical services removed the physici	Policy Holder Information  First Name: Last Name: Address: City: State: Zip: Policy Holders SS# Policy Holders Date of Birth: Gender: Male Relationship to Policy Holder: Delicy Holder: Delicy Holders Description Delicy Holder: Delicy Holders Delicy Holder: Delicy Holders Del