

PATIENT INFORMATION SHEET

PATIENT'S NAME:		DATE OF BIRTH:	AGE	SEX	MARITAL STATUS	
					S M W D	
MAILING ADDRESS:						
STREET			CITY		STATE	ZIP
HOME PHONE #:	WORK PHONE #	CELL PHONE #	SOCIAL SECURITY #			
EMERGENCY CONTACT: (OTHER THAN YOUR SPOUSE)						
NAME:			PHONE #			
ADDRESS:						

GUARANTOR'S NAME		DATE OF BIRTH:	AGE	SEX		
MAILING ADDRESS:						
STREET			CITY		STATE	ZIP
HOME PHONE #:		WORK PHONE #	CELL PHONE #			

REFERRED BY:	
--------------	--

IF PATIENT IS A MINOR OR STUDENT			
MOTHER'S NAME:		PHONE #	
FATHER'S NAME:		PHONE #	
PARENT OR GUARDIAN AUTHORIZED TO TREAT MINOR: SIGNATURE:			

PRIMARY INSURANCE INFORMATION			
INSURANCE COMPANY NAME:		POLICY:	
ADDRESS:		GROUP #	
NAME INSURED:			

SECONDARY INSURANCE INFORMATION			
INSURANCE COMPANY NAME:		POLICY:	
ADDRESS:		GROUP #	
NAME INSURED:			

TERTIARY INSURANCE INFORMATION			
INSURANCE COMPANY NAME:		POLICY:	
ADDRESS:		GROUP #	
NAME INSURED:			

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION/RECORDS AND LAB REPORTS TO THE INSURANCE CARRIER(S) LISTED ABOVE.

SIGNATURE: _____
 PATIENT OR PARENT/GUARDIAN OF MINOR

NOTE: UP TO FULL FEE WILL BE CHARGED IF NOT GIVEN 24 HR NOTICE FOR CANCELLED APPT
 A \$25 FEE WILL BE ADDED TO ACCOUNTS THAT ARE REFERRED TO AN OUTSIDE COLLECTIONS AGENCY