Patient Information Sheet

LAST NAME: ______________________ FIRST NAME: ______________________ M.I.________

ADDRESS: ______________________ CITY: __________________ STATE: _______ ZIP__________

HOME PHONE #: ______________ WORK PHONE #:____________ CELL PHONE #: ______________

DATE OF BIRTH: ________________ AGE: __________ MARITAL STATUS: ___________ M/F: _____

SOCIAL SECURITY #: ____________________ SPOUSE'S SOCIAL SECURITY #:___________________

EMPLOYED BY: _______________________ BUSINESS ADDRESS: _________________________

SPOUSE'S NAME: ______________________________ SPOUSE'S DOB: ____________________

SPOUSE EMPLOYED BY: ____________________ BUSINESS ADDRESS: _______________________

EMERGENCY CONTACT THAT DOES **NOT** LIVE WITH YOU: _________________________________

RELATIONSHIP: __________________________ PHONE #: _____________________________

PRIMARY INSURANCE: _______________________ NAME OF INSURED: ____________________

SECONDARY INSURANCE: ____________________ NAME OF INSURED: ____________________

REFERRED BY: ____________ PRIMARY CARE DOCTOR: _______________ PHONE #:__________

PHARMACY: _____________________________ PHONE #: ___________________________

PHARMACY ADDRESS/LOCATION: ____

Would you like access to Patient Portal to be able to communicate with the office through the internet in a safe and secure manner? _________YES _________NO

EMAIL ADDRESS: ____

I understand I am financially responsible for all charges for evaluation, testing, and treatment of my medical condition whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I assign directly to your office all benefits and authorize the use of this signature on all insurance submissions, whether manual or electronic.

PATIENT'S SIGNATURE: ______________________________________ DATE: _____________