PATIENT ACCOUNT INFORMATION

Patient

Patient Name ______________________________ DOB ________________ ☐ Male ☐ Female
Last First M. I.
Gender Identity ______________ Prefer not to Specify_________ Race ____________Ethnicity _____________ Prefer not to Specify_______
Address: ____ City: ____________________ State: ______ Zip Code: ________
Physician you are here to see _______________________________ Referred by: ____
Have you or any family member been seen here before? ☐ Yes ☐ No Patient Home Phone Number: ____________________

Responsible Party

Parent Name: ____Occupation____________________Employer: __________________
DOB: ____________ Home Address: _____________________________ City: _____________________ State: ______ Zip: ________
Phone Numbers Home: _________________ Work: ________________ Cell: __________________
SS #: __________________________ Marital Status: Single: ☐ Married: ☐ Widowed ☐ Divorced: ☐
Parent Name: ___________________________________Occupation: ____________________ Employer: _______________________
DOB: ____________ Home Address: _____________________________ City: _____________________ State: ______ Zip: ________
Phone Numbers Home: _________________ Work: ________________ Cell: __________________
SS #: __________________________ Marital Status: Single: ☐ Married: ☐ Widowed ☐ Divorced: ☐
Guardian: _____________________________________ Occupation: _____________________ Employer: _____________________
DOB: ______Home Address: ______________________Phone Home _______________ Work:_______________ Cell:________________
SS #: __________________________ Marital Status: Single: ☐ Married: ☐ Widowed ☐ Divorced: ☐

Primary Insurance Information

Insurance Company Name ____ HMO☐ PPO☐ Private☐
Insurance Address ____________________________________ City ________________________ State _____ Zip Code ______________
Name of
Insured____
Last First M. I.
Insurance ID # ____ Group Number _______________________________________

Secondary Insurance Information

Insurance Company Name ____ HMO☐ PPO☐ Private☐
Insurance Address ____________________________________ City ________________________ State _____ Zip Code_____________
Name of
Insured____
Last First M. I.
Insurance ID # ____ Group Number________________________________

Emergency Contact Information

Name of Person to Contact Other than Parent: ________________________________ Relationship________________________________
Address____
Home Phone ____ Work Phone____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand, and agree to hereby give consent for treatment.
Patient's Signature: ____ Date: __________________________