GENERAL INFORMATION

*Please be sure to complete all parts of this information form. Your insurance company requires us to submit nearly all of this information in order to process your claims. Incomplete forms result in delays, so if you are unsure about an entry please ask the office assistant.

DATE: _____

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____

STREET ADDRESS: _____

CITY_____ STATE: _____ ZIP: _____

MAILING ADDRESS (if different): _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

CELL PHONE: (_____) _____

CHECK ANY THAT APPLY: _____ Employed _____ Part-Time Student _____ Full-Time Student

PATIENT HEALTH INFORMATION

PRIMARY CARE PHYSICIAN: _____

DATE OF LATEST PHYSICAL EXAMINATION: _____

MEDICAL HISTORY/CURRENT PROBLEMS: _____

_____

CURRENT MEDICATION(S): _____

PAYMENT/INSURANCE INFORMATION

PERSON FINANCIALLY RESPONSIBLE:

NAME: _____ PHONE: (_____) _____

ADDRESS: _____

___ I AM NOT GOING THROUGH AN INSURANCE/MANAGED CARE COMPANY

___ I WILL BE GOING THROUGH AN INSURANCE/MANAGED CARE COMPANY

If you plan on using your health insurance, please present your insurance card to a staff member.

HAVE VISITS BEEN PRECERTIFIED? Y N

Failure to precertify visits when required will result in denial of claims and leave the responsibility for payment with the patient or person(s) financially responsible.

PAYMENTS/COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RECEIVED