Patient Information

(PLEASE PRINT)

NAME ______________________ DATE ____________

ADDRESS ______________ CITY ____________ ZIP ________

HOME# ____________ WK# ______________ CELL# ________

DATE OF BIRTH ______________ AGE ______ MARITAL STATUS ________

SS# ______________ RACE/ETHNICITY ______________

EMAIL ______________ REFERRED BY ____________ PCP ________

EMPLOYER ______________ POSTION ______________

SPOUSE'S NAME ______________ SPOUSE'S EMPLOYER ______________

PHARMACY NAME ______________ NUMBER ______________

MEDICATION REFILL POLICY: PLEASE CONTACT YOU PHARMACY FOR MEDICATION REFILLS. YOUR PHARMACY WILL FAX US A MEDICATION REFILL REQUEST WHICH THE PHYSICIAN WILL REVIEW. REFILL AUTHORIZATIONS MAY REQUIRE 24-48 HOURS. PLEASE ALLOW SUFFICIENT TIME FOR US TO PROCESS YOUR REFILL REQUEST.

INFORMATION OF PERSON RESPONSIBLE FOR BILL

(IF DIFFERENT THAN ABOVE)

NAME ______________________ DATE OF BIRTH ______________

RELATIONSHIP TO PATIENT ______________ SEX ________ HM# ____________

EMPLOYER ______________________ SS# ______________

INSURANCE

PRIMARY INSURANCE ______________________ MEMBER ID ______________

GROUP# ____________ POLICY HOLDER ______________ DOB ____________

RELATIONSHIP ____________ SS# ______________________

SECONDARY INSURANCE ______________________ MEMBER ID ______________________

GROUP# ______________ POLICY HOLDER ______________ DOB ______________

RELATIONSHIP ______________________ SS# ______________________

EMERGENCY CONTACT ______________________ NUMBER ______________________

AUTHORIZATIONS

BENEFITS TO PHYSICIANS:

I HEARBY AUTHORIZE PAYMENTS DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS. I ALSO UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY MY INSURANCE COMPANY.

SIGNED____

(PATIENT OR PARENT IF MINOR)

RELEASE OF INFORMATION:

I HEARBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES. PHOTOSTAT OF THE ABOVE IS VALID AS THE ORIGINAL.

I UNDERSTAND ALL THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. MY SIGNATURE INDICATES THAT I HAVE READ THE ABOVE AND GRANT THE REQUEST OF AUTHORIZATIONS.

DATE____________________20_____ **SIGNED________________________________**

(INSURED PERSON)