PATIENT INFORMATION SHEET

Patient's Name_____ **Age**_____ **Birth Date**_____
Address_____ **City**_____ **State**____ **Zip**_____
Home Phone_____ **Work Phone**_____ **SS#**_____
Drivers License#_____ **Sex**_____ **Referred By**_____
E-mail Address_____ **Cell Phone#**_____

Spouse Information
Name_____ **Home Phone**_____ **SS#**_____
Address_____ **Drivers License#**_____
Employer_____ **Address**_____ **Phone#**_____

Responsible Party Information
Name_____ **Birth Date**_____ **Home Phone**_____
Address_____ **Drivers License#**_____
Employer_____ **Address**_____
Employer's Phone_____ **SS#**_____ **Relation to Insured**_____

Insurance Information
Insured's Name_____ **Birth Date**_____ **SS#**_____
Insurance Company Name_____
Insurance Address_____
Group Name_____ **Policy#**_____ **Group#**_____
Alternate Insured's Name_____ **SS#**_____
Alternate Insurance Co._____ **Phone Number**_____
Policy Number_____ **Group Number**_____

Emergency Information
Name of Person to Contact_____ **Home Phone**_____
Address_____ **Cell Phone**_____
Work Number_____ **Relationship**_____

Authorization of Assignment
I hereby authorize _____ M.D. to furnish information to all pertinent insurance carriers concerning my illness and treatments. I am aware, you are billing my insurance company as a courtesy to me. I also, irrevocably assign Dr. _____, all payments including any unpaid or denied insurance balances for my medical treatment and collections if necessary.

Responsible Party's Signature_____ **Date**_____