PATIENT INFORMATION SHEET

Patient's Name _____
First Middle Last

Mailing Address _____
Street # Street Name Apt#

_____
City State Zip

Date of Birth _____/_____/_____ **SSN** _____

Home Phone _____ **Work Phone** _____ **Cell** _____

Employer _____ **Email Address** _____

Primary Care Physician _____

Please Circle: Male or Female Married Single Divorced Widowed

Name of Primary Insurance Company _____

Name of Policy Holder _____**Address**_____

Date of Birth _____ **SSN** _____ **Relation to Patient** _____

How did you hear about us?
Internet____ Provider Book____ Newspaper ____ Friend/Relative ____ Magazine ____ Radio ____
TV____ Phone Book____ Physician's Name _____

PLEASE PRESENT INSURANCE CARDS AND CO-PAY TO RECEPTIONIST AT EACH SCHEDULED APPOINTMENT.

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of the office. Co-pays are required at the time of registration, payment (self pay) the day services are rendered, and a no show fee of $25.00 for failure to cancel an appointment 24 hours prior. Your signature authorizes the Doctor to release such medical benefits to Doctor when an assigned claim is filed. I agree if my account is turned over to collection agency I will be held responsible for any collection fees of 30% involved in collection on my account.

Do we have your permission to:

Discuss your medical condition with any member of your household? Yes_____ No _____

If yes, whom? _____ Relationship _____

Email your test results? Yes _____No _____

Leave a message on your answering machine at home? Yes _____ No_____

Leave a message at your place of employment? Yes _____ No _____

Leave a message on your cell phone? Yes _____ No _____

(Due to HIPPA Privacy Policies the above must be completed or we will not be able to discuss your information)

Patient or Responsible Party Signature _____ **Date** _____