# CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

DATE

## PATIENT INFORMATION:

FULL NAME DATE OF BIRTH AGE Mal Female

ADDRESS APT# SSN

CITY STATE ZIP CODE HOME PHONE

ALTERNATE PHONE (CELL): ( ) EMAIL ADDRESS:

EMPLOYER'S NAME OCCUPATION

WORK ADDRESS CITY STATE ZIP

WORK PH. # ( ) EXT. DATE SYMPTOMS BEGAN

MARITAL STATUS: SINGLE MARRIED WIDOWED HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT PHONE

## CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT A PERSONAL INJURY A WORK INJURY OTHER

TYPE OF CLAIM: CASH GROUP HEALTH INS PERSONAL INJURY WORKER'S COMP MEDICARE

I WILL BE PAYING TODAY BY CASH CHECK VISA MASTERCARD AMEX DISCOVER OTHER

## INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF SPOUSE OTHER CHILD SPOUSE:

INSURED'S EMPLOYER SAME AS ABOVE

INSURED'S SSN SAME AS ABOVE SSN INSURED'S DOB SAME AS ABOVE

PRIMARY INSURANCE CO. ADDRESS

CITY STATE ZIP CODE PHONE#(

POLICY NUMBER GROUP NUMBER

SECONDARY INSURANCE CO. ADDRESS

CITY STATE ZIP CODE PHONE#(

POLICY NUMBER GROUP NUMBER

## AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: Date:

Guardian Signature: Date: