PATIENT INFORMATION

Patient's Name _____ (Last / First / Middle) Preferred Name _____ Birthdate _____

Sex _____ Race _____ Age _____

Address _____ Home Phone _____ Work Phone _____

City, State, Zip _____ Social Security No. _____

Employer _____ Address _____

Spouse's Name _____ Spouse's Employer _____ Emp. Address _____

Name of Nearest Relative Not Living with You _____ Phone (_____) _____-_____

Relative's Address _____ City, State, Zip _____

Parent or Guardian Name if Patient Under Age 21 _____ Phone _____

Parent or Guardian Address _____ City, State, Zip _____

Have any Members of your Family Been Patients Before? _____

How Did You Find Out About Our Office? _____

ACCOUNT INFORMATION

Person Responsible for Account _____ (Last / First / Middle) Relationship to Patient _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Social Security No. _____ Birthdate _____

Employer _____ Address _____ Name of Bank _____

Spouse's Name _____ Spouse's Employer _____ Emp. Address _____

MEDICAL HISTORY

Name of Physician _____ Date of Last Physical Exam _____ Why? _____

Do you have any medical condition that you receive regular treatment for? _____ If so, what? _____

Do you have any medical conditions? _____

LIST MEDICINES YOU ARE ALLERGIC TO _____

Other Allergies _____

CURRENT MEDICATIONS (Name and Dose) _____

_____

Do you smoke? _____ How much? _____ Do you use smokeless tobacco? _____

Serious Illnesses (Include Year) _____

Serious Injuries (Include Year) _____

Cancer, Tumor, or Malignancy (Include Year) _____

Hospital Admissions (Year and Reason) _____

Operations (Year and Procedure) _____

(Women) Are you pregnant? _____ How many months? _____

Have you ever had any of the following? (Circle)

High Blood Pressure	Free Bleeding	Hepatitis	AIDS
Congenital Heart Defect	Anemia	Yellow Jaundice	Thyroid Disease
Mitral Valve Prolapse	Pregnancy	Liver Disease	Diabetes
Heart Murmur	Sinus	Ulcer	Arthritis
Chest Pain	Tuberculosis	Black Stools	Glaucoma
Heart Attack	Emphysema	Venereal Disease	Fainting Spells
Rheumatic Fever	Asthma	Kidney Disease	Convulsions
Stroke	Shortness of Breath	Hormone Disorder	Seizures
Blood Transfusion	Swelling of Hands or Feet	Cortisone or Steroid Therapy	Epilepsy

Anything else we should know about you _____

_____

To the best of my knowledge the above confidential information is accurate. If the patient is a minor, I give my permission for treatment. I understand I am responsible for payment at the conclusion of each appointment unless prior arrangements are made. I agree to pay all costs of collection including a reasonable attorney's fee. I authorize the use of credit bureau reports where appropriate. I further understand that any account balance more than 60 days old will incur a billing charge each month.

Signature _____ Date _____

If you have Dental Insurance, please fill out the back side of this form.

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security No. _____ Insured's Birthdate _____

Insured's Address _____ City, State, Zip _____

Employer _____ Employer Address _____ City, State, Zip _____

Insurance Co. _____ Ins. Co. Address _____ City, State, Zip _____

Insurance Co. Phone ( ) _____ Policy or Group No. _____ Union or Local No. _____

IF YOU HAVE DUAL INSURANCE COVERAGE:

Second Insured's Name _____ Insured's Social Security No. _____ Insured's Birthdate _____

Insured's Address _____ City, State, Zip _____

Employer _____ Employer Address _____ City, State, Zip _____

Insurance Co. _____ Ins. Co. Address _____ City, State, Zip _____

Insurance Co. Phone ( ) _____ Policy or Group No. _____ Union or Local No. _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to your office of the group insurance benefits otherwise payable to me.

Signature _____ Date _____

(If assignment of benefits is not granted, payment in full is required at the conclusion of each appointment)

INSURANCE AGREEMENT

I hereby authorize the release of any information necessary to process this claim. I understand that this office is only filing my insurance as a courtesy. I remain totally responsible for the collection of insurance benefits and I am totally responsible for all charges incurred in this office including those not covered or denied by my insurance carrier.

Signature _____ Date _____