Personal Physicians

PATIENT INFORMATION

All information must be filled out in full- please print

Today's date:	PCP:

Patient's last name:	First:	Middle:		Marital status (circle one) ***
				Single / Mar / Div / Sep / Wid

Birth date:	Age:	Sex: M F	Is this patient a minor? Yes No - If yes please fill out parent's information.

Street address:	SSN:	Phone #:

P.O. box:	City:	State:	ZIP Code:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:				

Patients Mother's Info/Spouse Info ***	Birth date:	Address (if different):	Home phone no.:
	/ /		( )
Is this person a patient here?	❑ Yes ❑ No		Social Security #
Occupation:	Employer:	Employer address:	Employer phone no.:( )

Patients Father's Info	Birth date:	Address (if different):	Home phone no.:
	/ /		( )
Is this person a patient here?	❑ Yes ❑ No		Social Security #
Occupation:	Employer:	Employer address:	Employer phone no.:( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please note: In cases of divorce, it is our policy that responsibility of any amount left owed after insurance has paid will be the responsibility of the <u>parent</u> who is brings the child for their appointments.

Primary Insurance Name					
Subscriber's name:	**Subscriber's S.S. no**.:	DOB	Group #:	Policy no.:	Co-payment:
		/ /			$
Employer:		Address:		Phone:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Secondary Insurance Carrier					
Subscriber's name:	**Subscriber's S.S. no**.:	DOB	Group #:	Policy no.:	Co-payment:
		/ /			$
Employer:		Address:		Phone:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I *<u>am financially responsible for any balance</u>*. I also authorize ABC Office or insurance company to release any information required to process my claims. I also understand that if my account becomes delinquent and is sent over to collections there will be a 28-40% fee accessed on the account balance.

Patient/Guardian signature *Date*