## PATIENT INFORMATION

PATIENT NAME _____

PERMENANT ADDRESS_____

_____

LOCAL ADDRESS_____

_____

PHONE: Home _____ Work _____ Cell _____

SEX M___F___ DATE OF BIRTH_____AGE_____

MARITAL STATUS M__S__D__W__ SPOUSE NAME_____

PATIENT SOCIAL SECURITY _____-_____-_____

OCCUPATION_____

EMPLOYER_____

EMPLOYER ADDRESS_____

EMERGENCY CONTACTNAME_____RELATIONSHIP_____

EMERGENCY CONTACT PHONE NUMBER _____

PRIMARY CARE PHYSICIAN _____PHONE #_____

PHARMACY NAME AND PHONE NUMBER_____

## INSURANCE INFORMATION

INSURANCE COMPANY #1

COMPANY NAME_____

ADDRESS_____

INSURED NAME_____

ID#_____GROUP #_____

PRIMARY INSURED: SELF_____ SPOUSE_____

SPOUSE SOCIAL SECURITY _____-_____-_____

SPOUSE EMPLOYER_____ SPOUSE DATE OF BIRTH_____

INSURANCE COMPANY #2

COMPANY NAME_____

ADDRESS_____

INSURED NAME_____

ID#_____GROUP #_____

1. I agree to pay $ 25.00 fine if I am unable to keep my appointment and unable to reschedule or notify the office 24 hours in advance.
2. I am personally responsible for charges not covered by the insurance.
3. I permit a copy of authorization to be used in place of the original and request payment of insurance benefits either to myself or to the party who accepts assignment.

_____ _____

PATIENT SIGNATURE DATE