Patient Information Sheet

Last Name:_____ First Name:_____M.I _____

Address:_____

City,State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Email: _____

Date of Birth:_____ Sex: Male Female

Preferred Language_____ Ethnicity: _____

Marital Status: Married Widowed Single Divorced Separated

Drivers License #_____ State: _____

Employer:_____ Phone:_____

Employer Address:_____

Emergency Contact: _____

Phone: _____ Relationship : _____

Primary Insurance: _____

Insurance Address:_____

ID #:_____Group #_____ Co-pay $_____

Secondary Insurance:_____

Insurance Address:_____

Referred By:_____Primary Dr:_____ Phone:_____

I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all insure submissions, whether manual or electronic

Patient Signature: _____ Date: _____