# Confidential Patient Information

*The following information is needed in order to better serve you. Please complete all questions.*
*If you need help, please ask the receptionist. PLEASE PRINT.*

Today's Date:_____

Name: _____ Home Phone:_____

Address:_____ City: _____ State: _____ Zip: _____

Age:_____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Referred by: _____ E-mail Address:_____

Please Circle Type of Payment: ☐ Cash ☐ Check ☐ MasterCard/Visa

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____ Your SS#: _____

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company: _____

Insurance Plan/Group#: _____ Your Work Hours: _____

Do You Have Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer:_____ Occupation: _____

Office Phone: _____ Cell Phone: _____Spouse's SS#:_____

Describe The Major Complaints That Bring You To Our Office: _____

_____

_____

Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident? ☐ Auto ☐ Work/Job ☐ At Home ☐ Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

***Patient's Signature:*** _____ ***Date:*** _____

***Guardian's Signature (For Minors):*** _____***Date:*** _____

***Notice to our new patients:*** Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.