PATIENT INFORMATION ❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Name _____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Social Security #_____ Sex: ❑ Male ❑ Female

ADDRESS:

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:_____ Phone: ( )_____ Ext:_____

Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____ SS#_____ Sex: ❑ Male ❑ Female

Policy #:_____ Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

Employer Name: _____

Employer Address: _____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other_____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____ Phone: ( )_____ Ext:_____

Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____ SS#_____ Sex: ❑ Male ❑ Female

Policy #:_____ Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

Employer Name: _____

Employer Address: _____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other_____

Referred by: _____

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_____ Today's Date ____/____/____

Other family members that are patients _____

Primary Care Physician _____ Phone ( )_____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified?_____ Phone ( )_____

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Phone # (evening): (_____)_____

May we leave personal medical information on your answering machine at home?

❑ YES ❑ NO

May we e-mail personal medical information to you?

❑ YES ❑ NO E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ Date ____/____/____