

**PATIENT INFORMATION RECORD**

PLEASE PRINT

Date: \_\_\_\_\_

Have you been a patient at our clinic before? NO  YES  When? \_\_\_\_\_

Please answer each item. If an item does not pertain to you, indicate so with a check (✓).

**PATIENT'S**

Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
LAST FIRST MIDDLE

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**WHO WILL BE RESPONSIBLE FOR THE PATIENT'S MEDICAL EXPENSES?**

Check One:  Patient  Spouse  Mother  Father  Other \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ SS # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**INSURANCE INFORMATION:**

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Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured's I. D. # \_\_\_\_\_ Group # \_\_\_\_\_ Family Coverage  Yes  No

Patient's Relationship to Insured:  self  spouse  child  other

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Secondary Carrier \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured's I. D. # \_\_\_\_\_ Group # \_\_\_\_\_ Family Coverage  Yes  No

Patient's Relationship to Insured:  self  spouse  child  other

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. **I understand I am financially responsible for charges not covered by my insurance.** I further authorize:

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier information needed to determine benefits.

**A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY ME IN WRITING.**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT IF MINOR Date

In Case of Emergency, Notify \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) Relationship \_\_\_\_\_

How were you referred to the Clinic? \_\_\_\_\_

Please list the names of other members of your family who are also patients here: \_\_\_\_\_

