

FOR OFFICE USE:  
ACCT# \_\_\_\_\_  
DOCTOR: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Soc.Sec.#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Additional Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Responsible Party: \_\_\_\_\_ Soc.Sec.#: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Additional Phone: \_\_\_\_\_

**FOR EMERGENCIES**

Relative other than Spouse/Parent: \_\_\_\_\_ Relation: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Ins. Co.: \_\_\_\_\_ Secondary Ins. Co.: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**NOTE: IF YOU DO NOT HAVE INSURANCE COVERAGE, FULL PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT.**

IF WE ARE BILLING YOUR INSURANCE COMPANY, PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST TO PHOTOCOPY AND SIGN THE AUTHORIZATIONS ON THE BACK OF THIS FORM. IF YOU DO NOT HAVE YOUR INSURANCE CARDS YOU ARE RESPONSIBLE TO PAY FOR SERVICES RENDERED AT THE TIME OF SERVICE.

Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Referring Doctor: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_

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**SIGNATURE AUTHORIZATION FOR PAYMENT**

I request that payment of authorized Medicare and or any other insurance benefits be made directly to \_\_\_\_\_ for services furnished to me. I authorize any holder of medical information about me to be released to \_\_\_\_\_ and their agents any information needed to determine these benefits or the benefits for related services. I am aware that any cosmetic procedure will not be billed to my insurance company and that I am responsible for payment at the time of service. I understand that if my financial account needs collection all collection fees will be added to the original balance.

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

If under 18, responsible party signature: \_\_\_\_\_  
Relation: \_\_\_\_\_

**RECORDS RELEASE AUTHORIZATION**

I hereby authorize and request \_\_\_\_\_ to release the complete medical records in their possession concerning my illness and or treatment to my primary care physician or my insurance company.

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

**WAIVER OF REFERRAL**

(For HMO policies only)

I understand that I am responsible for obtaining my referrals from my primary care physician for each and every visit with this office. I understand that **IF** I do not have my referral for my visit, or I wish to waive the use of my referral under my HMO program, I am responsible for my balance.

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

**RELEASE OF MEDICAL CONDITION TO OTHERS**

I do \_\_\_\_\_ I do NOT: Authorize \_\_\_\_\_ or their agents to discuss my medical condition or results of labs or path reports with family members listed below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

THANK YOU!!