Patient Demographics

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Today's Date _____–_____–_____
Month Day Year

I. Patient

Name _____ ____ _____ Birthdate _____–_____–_____
First MI Last Month Day Year

Address _____ _____ _____ _____
Street City State Zip Code

Marital Status ☐ S ☐ M ☐ D ☐ W

Gender ☐ M ☐ F

Phone *(check pref. #)* ☐ Home ( ) _____–_____ ☐ Work ( ) _____–_____

☐ Cell ( ) _____–_____ ☐ Emerg. ( ) _____–_____

Employer _____

Emp.'s Address _____ _____ _____ _____
Street City State Zip Code

Referring Physician _____ or friend, family _____

Family Physician _____

II. Responsible Party (OR SPOUSE)

Name _____ ____ _____
First MI Last

Address _____ _____ _____ _____
Street City State Zip Code

Phone *(check pref. #)* ☐ Home ( ) _____–_____ ☐ Work ( ) _____–_____

☐ Cell ( ) _____–_____ ☐ Emerg. ( ) _____–_____

Employer _____

Emp.'s Address _____ _____ _____ _____
Street City State Zip Code

III. Emergency Contact Person

☐ Spouse/Responsible Party listed above *(go to section **IV.**)*

Name _____ ____ _____ Relationship _____
First MI Last to Patient (e.g. friend, son)

Phone *(check pref. #)* ☐ Home ( ) _____–_____ ☐ Work ( ) _____–_____

☐ Cell ( ) _____–_____ ☐ Emerg. ( ) _____–_____

IV. Acceptance of Terms and Conditions

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical information necessary to process claims with my insurance company.

ASSIGNMENT OF BENEFITS: I authorize the insurance company or any third party payor to pay any benefits due directly to this office.

PAYMENT POLICY: I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. **Non-covered services, co-insurance, deductibles and balances deemed as patient responsibility by my insurance company will be billed to me. Co-pays are due at time of service by cash or personal check only.**

I agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature _____ Date _____–_____–_____
Month Day Year