PATIENT INFORMATION

I. PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: ______________

Social Security #: ______________________ Sex: ☐ Male ☐ Female

Marital Status: ☐ Minor *(Under 18 yrs.)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Responsible Party: ☐ Self *(If Self, proceed to Section II)* ☐ Parent/Guardian *(If parent/guardian, list responsible party below)*

Responsible Party Name: ______________________ Relationship to Patient: ______________

II. RESPONSIBLE PARTY CONTACT INFORMATION *(All billing statements will be mailed to this address)*

Home Address: ____

City: __________________________ State: ____________ Zip: ______________

Home Phone #: ______________________ Work/Cell Phone #: ______________________

Employer: __________________________ Position: ______________________

III. EMERGENCY CONTACT INFORMATION

Contact Name: __________________________ Relationship to Patient: ______________

Home Phone #: ______________________ Work/Cell Phone #: ______________________

IV. PRIMARY INSURANCE CARDHOLDER INFORMATION

(Our office bills primary insurance for patients with our network providers: Blue Cross Blue Shield and Medicare. Patients are responsible for billing all out-of-network and secondary insurance.)

Cardholder Name: __________________________ Relationship to Patient: ______________

Cardholder Date of Birth: ______________ Insurance Company: ______________________

Insurance ID #:______________________ Group #:______________________

Home Address: ____

City: __________________________ State: ____________ Zip: ______________

Home Phone #: ______________________ Work/Cell Phone #: ______________________

V. AUTHORIZATION & CONSENT FOR MEDICAL TREATMENT

With my signature below, I hereby request and consent to medical treatment. Consent is hereby implied for any and all medical, laboratory, and diagnostic procedures deemed necessary for proper medical care by my physician. Consent is also implied for any medical procedures that may become necessary in the event of an emergency, unless otherwise specified.

Signature of Patient or Parent/Guardian ______________________________ **Date**____________

VI. AUTHORIZATION & RELEASE OF INFORMATION REGARDING REIMBURSEMENT

I authorize the release of any information including the diagnosis and the records of any treatment or examination including mental health records rendered to me or my dependents during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor's or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent/Guardian ______________________________ **Date**____________