Patient Profile

Patient Information

Name: _____

Address: _____

_____

City, State, Zip _____

Home Phone: _____

Cell Phone: _____

E-mail Address: _____ [ ] M [ ] F

Date of Birth: _____

Social Security # _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Referring Physician: _____

Primary Care Physician: _____

Patient Employment

[ ] Employed [ ] Retired [ ] Other

Work Phone: _____

Employer: _____

Emergency Contacts: (Include Relationship & Contact Information)

_____

_____

_____

Guarantor (Person Financially responsible)

[ ] Same as patient

Name: _____

Address: _____

City, State, Zip _____

Guarantor Employment

Employer: _____

Phone: _____

Social Security # _____

Date of Birth: _____

Primary Insurance

[ ] Same as patient [ ] Same as guarantor [ ] Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security # _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

Secondary Insurance

[ ] Same as patient [ ] Same as guarantor [ ] other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security # _____

Insured ID: _____

Policy Group _____

Date of Birth: _____

Authorization of Benefits:

I hereby authorize my insurance benefits to be paid directly to the above named Doctor, realizing that I am responsible for non-covered services, co-pays and deductibles. I hereby authorize the release of pertinent medical information to my insurance carrier (s) upon request. If the patient is a minor child, I hereby authorize the clinic to provide medical services in my absence.

_____

Patient/ Guardian Signature