PATIENT INFORMATION ☐New Patient ☐Name Change ☐Address Change ☐Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/______

Name:____
Last *First* *M.I.*

Date of Birth: ___/___/___ Age: ____ Social Security #________________ Sex: ☐Male ☐ Female

ADDRESS:

Mailing Address:____
City *State* *Zip*

Home Phone: ( )____________________ Work Phone: ( )____________________
Cell Phone: ( )____________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referred by:____

PARENT, SPOUSE, OR RESPONSIBLE PARTY ***(if different from patient)***

Name:____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address:____
City *State* *Zip*

Home Phone: ( )____________________ Work Phone: ( )____________________

INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name:______________________________ Phone: ( )______________Ext:____

Address of Claim Center: ____
____
City *State* *Zip*
Name of Policy Holder (Insured):______________________________
Policy Holder (Insured) Date of Birth: ____/____/____ SS# ________________ Sex: ☐ Male ☐ Female
Policy #:______________________________ Group Name or #: ____________________
Policy Type: ☐ HMO ☐ PPO
Employer Name:____
Employer Address: ____
If patient is child, check relationship: ☐ Mother ☐ Father ☐ Other____________________

INSURANCE COVERAGE – SECONDARY:

Insurance Co. Name:______________________________ Phone: ( )______________Ext:____

Address of Claim Center:____
____
City *State* *Zip*
Name of Policy Holder (Insured):______________________________
Policy Holder (Insured) Date of Birth: ____/____/____ SS#________________ Sex: ☐ Male ☐ Female
Policy #:______________________________ Group Name or #:____________________
Policy Type: ☐ HMO ☐ PPO
Employer Name:____
Employer Address:____
If patient is child, check relationship: ☐ Mother ☐ Father ☐ Other____________________

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_________________________________ Today's Date ____/____/____

Other family members that are patients: _________________________________

Primary Care Physician:_________________________ Phone: (   )______________

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? _________________________

Phone # (   )_____________________

Do you give our office permission to discuss your medical information with family members?
□ YES □ NO If yes, please provide their names and phone numbers below.

Name:_____________________________ Relationship:____________________

Phone # (day): (_____)_________________ Phone # (evening): (_____)__________

May we leave personal medical information on your answering machine at home?

□ YES □ NO

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature ___________________________ Date____/____/____

PAYMENT POLICY:

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services.

Patient or Responsible Party Signature ___________________________ Date ____/____/____