PATIENT DATA SHEET

Patient Information

SSN (###-##-####)

Last Name | First Name | MI

Date of Birth (MM/DD/YYYY) | ☐ Female | ☐ Male

Marital Status ☐ M ☐ S ☐ D ☐ W

Patient Address

Address Line One

Address Line Two

City | State | Zip | Zip+4

Patient Telephone, Email

Email

Telephone (Primary) | Phone Type ☐ Home ☐ Business ☐ Mobile

Telephone (Sec.) | Phone Type ☐ Home ☐ Business ☐ Mobile

Emergency Contact

Name | Relationship

Email

Telephone (Primary) | Phone Type ☐ Home ☐ Business ☐ Mobile

Telephone (Sec.) | Phone Type ☐ Home ☐ Business ☐ Mobile

School / Employer Information

School / Employer Name | Telephone

Address

City | State | Zip | Zip+4

☐ Full time ☐ Part time

Primary Insurance

Insurance Company

ID or Group #

Group Name (or Company Name)

Telephone Number (###) ###-####

Name of Policy Holder | Relationship to Patient

Secondary Insurance

Insurance Company

ID or Group #

Group Name (or Company Name)

Telephone Number (###) ###-####

Name of Policy Holder | Relationship to Patient

PEASE READ AND SIGN BELOW:
I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. I hereby give authorization for treatment.

X

Signature | Date

Referred By:

Name

Email

Telephone | Phone Type ☐ Home ☐ Business ☐ Mobile

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