

WELCOME

PATIENT INFORMATION

Date _____
SS# / SIN _____
Patient Name _____
Wishes to be called _____
Mailing Address _____

Physical Address _____

Sex Female Male Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for ___ years
Patient Employer/School _____
Employer/School Address _____

Employer/School Phone () _____
Referred by _____

PHONE NUMBERS

Home Phone _____
Work Phone _____ Ext. # _____
Cell Phone _____
Where do you prefer to receive calls?
 Home Work Cell
Best time to reach you? _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____
Phone Numbers _____

Primary Care Dr. _____

WHO IS RESPONSIBLE FOR THIS BILL

Same as Above

Name _____
Relationship to Patient Self Parent Spouse Other
SS# / SIN _____ Birthdate _____
Mailing Address _____

Physical Address _____

 Employed; F/T P/T Employer _____
 Not Employed Retired

Occupation _____ Work Phone _____
Home Phone _____ Cell Phone _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and doctor's assistants or designed replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Date: _____ Signed: _____

PRIMARY INSURANCE

Name of Insured _____
Relationship to Patient Self Parent Spouse Other
Insured's birth date _____
SS# / SIN _____
Mailing Address _____

 Employed; F/T P/T Employer _____
 Not Employed Retired
Insurance Company _____
Group # _____ Employee/Cert. # _____
Ins. Co. Address _____

SECONDARY INSURANCE

No Secondary Insurance
Name of Insured _____
Relationship to Patient Self Parent Spouse Other
Insured's birthdate _____
SS# / SIN _____
Mailing Address _____

 Employed; F/T P/T Employer _____
 Not Employed Retired
Insurance Company _____
Group # _____ Employee/Cert. # _____
Ins. Co. Address _____

WAS THIS AN ACCIDENT? YES NO, DATE INJ _____

IS THIS WORK COMP? YES NO, DATE INJ _____

ALL INSURANCE ASSIGNMENT AUTHORIZATION AND

RELEASE OF INFORMATION

I certify that I have insurance coverage with _____ and assign directly to _____ all Insurance/Medicare/Medigap/Medicaid benefits, if any, otherwise payable to me for service rendered. **I understand that I am financially responsible for all charges whether or not paid by Insurance/Medicare/Medigap/Medicaid.** I authorize the use of my signature on all Insurance/Medicare/Medigap/Medicaid submissions. The above-named provider may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance/Medicare/Medigap/Medicaid benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Beneficiary, Guardian or Personal Representative

Date

**Signature is required*