Patient # _____
(Office Use Only)

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need you to complete all of the following information.
Please print. All information furnished will be confidential and maintained per HIPAA privacy guidelines.

Patient Name _____ (First Name) (Middle Initial) (Last Name)

Street Address _____ City _____ State _____ Zip _____

HIPAA Privacy: May we mail correspondence addressed to you to the above street address? ☐ Yes ☐ No

SSN _____ Date of Birth _____ **Check Gender:** ☐ Male ☐ Female

Check Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Home Phone _____ Work Phone _____ Extension _____ Cell Phone _____

HIPAA Privacy: May we leave a message for you with an individual or answering machine at the above phone numbers? ☐ Yes ☐ No

Check Student Status: ☐ Not A Student ☐ Full Time ☐ Part Time School/College Name _____

School Address _____ City _____ State _____ Zip _____

Check Employment Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Active Duty Military ☐ Self Employed ☐ Not Employed

Place of Employment _____ (Patient Employer or if minor Parent Employer) Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Emergency Phone _____

In case of medical emergency, **if the patient is of school age 15+**, my signature below serves as my authorization to treat in my absence.

Print Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____

RESPONSIBLE PARTY *(Complete this section only if someone other than the patient is financially responsible)*

Responsible Party Name _____ (First Name) (Middle Initial) (Last Name)

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Extension _____ Cell Phone _____

Check Patient Relationship to Responsible Party: ☐ Spouse ☐ Child ☐ Other: _____

***SELF PAY: PATIENT IS NOT COVERED BY MEDICAL INSURANCE:** ☐ Check here if patient is not covered by a medical insurance plan

PRIMARY INSURANCE

Insurance Company Name _____ Policy ID _____ Group ID _____

Subscriber Name _____ (Subscriber = Employee/Retiree with insurance benefits) Subscriber SSN _____ Subscriber DOB _____

Check Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Check Co-pay Amount: ☐ $0 (None) ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40 ☐ $45 ☐ Other: _____

SECONDARY INSURANCE

Insurance Company Name _____ Policy ID _____ Group ID _____

Subscriber Name _____ (Subscriber = Employee/Retiree with insurance benefits) Subscriber SSN _____ Subscriber DOB _____

Check Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Check Co-pay Amount: ☐ $0 (None) ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40 ☐ $45 ☐ Other: _____

My signature below authorizes the release of information pertaining to my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits for services rendered directly to the physician. I agree to be responsible for all charges incurred should it be determined that I am not eligible by my insurance carrier. Additionally, I have received a copy of the practice's HIPAA (Health Insurance Portability and Accountability Act) policy to protect the confidentiality of my medical information.

Patient Signature (or if patient is a minor Parent/Guardian Signature) _____ Date _____

(Office Use Only) Enter Year of Annual Update: _____ Date Tiger Registration Updated: _____

Check attached document: ☐ Driver's License ☐ State issued ID ☐ Passport ☐ Resident Alien ID ☐ Other _____

Check attached document: ☐ Front & Back of Primary Insurance Card ☐ Front & Back of Secondary Insurance Card ☐ Self Pay (no attachment) FORM 1/0606