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Confidential Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____ M / F

Address: _____ S.S.N.# _____ - _____ - _____ Marital Status: _____

City & Zip: _____ Home Phone:_____

Cell Phone: _____ E-Mail: _____

Number where patient information may be left on recording system: _____

If minor, please complete below (only if different):

Mother Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

Father Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

Minor's School:_____ Phone:_____

Should prior authorizations be necessary for specific medications, the following information is needed:

Insurance Company: _____ Phone: _____

Insured Name: _____ Date of Birth: _____

Member #: _____

Local Pharmacy:

Name: _____ Phone: _____

RECORD RELEASE AUTHORIZATION/PAYMENT PROMISE

I HEREBY AUTHORIZE THE PHYSICIAN INDICATED ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS AND PHARMACIES CONCERNING THIS ILLNESS, TREATMENT, OR MEDICATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. OUTSTANDING BILLS PAID BY CREDIT CARD WILL INCLUDE A FOUR PERCENT ADMINISTRATIVE FEE. **I ALSO UNDERSTAND THAT I WILL BE BILLED FOR APPOINTMENTS NOT CANCELLED AT LEAST 1 FULL BUSINESS DAY IN ADVANCE, AND ACKNOWLEDGE MY OBLIGATION TO PAY FOR THE RESERVED APPOINTMENT TIME.**

Signature of Patient or Patient's Legal Guardian Date