

Date: \_\_\_\_\_

## PATIENT INFORMATION RECORD

Patients Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

(Last) (First) (Middle Initial)

Age \_\_\_\_\_ Sex M F Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mailing Address if different than above \_\_\_\_\_

In Case of Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_

(Last) (First) (Middle Initial)

Spouse or Parent Occupation \_\_\_\_\_

How were you referred to this office \_\_\_\_\_

Person responsible for payment \_\_\_\_\_

(Last) (First) (Middle Initial)

Address \_\_\_\_\_ Phone # \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance Carrier** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurer's ID # \_\_\_\_\_ Group # \_\_\_\_\_ Medicare/Medicaid # \_\_\_\_\_

Insurer's Name \_\_\_\_\_ Insurer's Date of Birth \_\_\_\_\_

Patient's Relationship to the insured above – (circle) SELF SPOUSE CHILD OTHER

**Secondary Insurance Carrier** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurer's ID # \_\_\_\_\_ Group # \_\_\_\_\_ Medicare/Medicaid # \_\_\_\_\_

Insurer's Name \_\_\_\_\_ Insurer's Date of Birth \_\_\_\_\_

Patient's Relationship to the insured above (SELF SPOUSE CHILD OTHER)

PATIENTS'S OR ATHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the physician or supplier of services received. I authorize the release of any medical or other information necessary to process claims for serviced. I also request that payment of government benefits either to myself or to the provider accepting assignment of benefits on medical claims.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_