PATIENT INFORMATION FORM **PLEASE COMPLETE ENTIRE FORM**

Name: _____ Date of Birth:_____ SS#:_____
Last First MI
Address:_____ City/State:_____ Zip:_____
Home Phone:_____ Cell: _____ Work:_____
Email Address: _____ Age:_____ Sex: M / F

May we leave a message on an answering machine or voice mail for any of the numbers above?_____

Choose One: Married Single Divorced Widow
Spouses Name:_____ Spouses Date of Birth_____

Parents Name if Minor:_____ Parents Phone:_____
**Person Responsible for this Account:_____ Phone:_____

EMERGENCY CONTACT INFORMATION
Emergency Contact Person and Relationship:_____ Phone Number:_____

AUTHORIZED FAMILY/FRIEND: Whom may we speak to regarding your medical treatment/condition/billing?

_____ _____
Print Name and Relation to Patient Print Name and Relation to Patient

PHYSICIAN INFORMATION
Referring Provider _____ Primary Care Provider _____

EMPLOYMENT INFORMATION **Choose One:** Unemployed Employed Retired Disabled

Patients Employer:_____ Occupation: _____
Employers Address:_____ Employers Phone:_____

Is this visit related to a work related injury? YES/NO (**please see receptionist for additional form**)

Is this visit related to a Motor Vehicle Accident? YES/NO (if yes, **STOP immediately we DO NOT bill to NF**)

PRIMARY INSURANCE *****It is your responsibility to check with your Insurance Company to see if a referral is needed***
Name of Insured:_____ Relationship to Patient:_____ Birth date:_____
Insurance Company:_____ Subscriber/Member ID #:_____
SECONDARY INSURANCE
Name of Insured:_____ Relationship to Patient:_____ Birth Date:_____
Insurance Company:_____ Subscriber/Member ID#:_____

IMPORTANT INSURANCE INFORMATION: If your Insurance Carrier requires a REFERRAL and/or PRIOR Authorization prior to your appointment, it is up to you and/or your Referring Physician to obtain the authorization. If your claim is denied due to not having a referral and/or prior authorization, you will be responsible to pay the bill in full. I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any neglect on my party for failure to update insurance information.

I acknowledge that I have received and understand our office **Financial Policy & Procedures and Patient Disclosure Requirement.**

_____ _____
Patient/Responsibility Party's Signature Today's Date