PATIENT INFORMATION FORM 2022

(form must be completed in full)

Date ______________

Patient ______________________________
first m.i. last

☐ Married ☐ Single ☐ Widowed ☐ Divorced

☐ male
☐ female

Date of Birth ___/___/___ Age___

SS#______________ CDL#__________

Address ______________________________

City ______________ST____ Zip________

Phone #______________ ______________
home *cell*

Email ____________@____________

Occupation ______________________________

Employer ______________ Ph#__________

Emp Address______________________________

____

Responsible for bill: complete in full or ☐ same as above

☐ self ☐ spouse ☐ child ☐ employer ☐ other

Name ______________________DOB________

Address ______________________________

City ______________ST____ Zip________

Phone______________ ______________
home *cell*

SS# ______________________________

Employer______________________________

Employer Address ______________________

____

Occupation ______________________________

How were you referred to our office?

☐ Doctor ☐ Hospital ☐ Family ☐ Insurance ☐ Internet ☐ Friend

Name of person who referred you______________

Were you recently seen in hospital by our doctors? ☐ Yes ☐ No

EMERGENCY CONTACT

Name ______________ Relationship________

PH ______________________________
home *cell*

Address______________________________

____
City State Zip

INSURANCE INFORMATION (Insurance Cards required)

☐PPO ☐HMO ☐Medicare ☐POS ☐ Cash ☐WC ☐ Other

Primary Insurance ______________________

Ins Address ______________________

City______________ ST___ Zip__________

Subscriber ______________ DOB________

Member ID#______________Grp#________

Secondary Ins______________________

Ins Address ______________________

Subscriber ______________DOB ________

Member ID#______________Grp#________

CURRENT LIST OF PHYSICIANS

Primary Care______________Ph ____________

Cardiologist ______________Ph____________

Gen Surgeon______________Ph____________

Dermatologist______________Ph____________

Oncologist______________Ph____________

Other ______________________________

PHARMACY ______________________

Address______________________

Phone # ______________________

Authorization for Payment/Release of Medical Records

I authorize release of medical records & payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature ______________ ____________
(relationship to pt)

Photography Consent

I authorize the physician or his assistant to take photographs. The term "photograph": includes all standard & digital photographs, videotapes, etc. These photographs are the doctor's property and will be a permanent part of the record.

Signature ______________Date________

☐ HIPAA Informed Release on File (date)______________

12/2020