REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:____ Today's Date ____/____/____

Other family members that are patients ____

Referred by: ____

Primary Care Physician ___________________________ Phone (   )______________

EMERGENCY CONTACT INFORMATION:

In case of mergency, who should be notified?____________________ Phone (   )______________

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: __________________________________ Relationship: _________________________

Phone # (day): (______)_______________ Phone # (evening): (_____)_______________

May we leave personal medical information on your answering machine at home?

❑ YES ❑ NO

May we e-mail personal medical information to you?

❑ YES ❑ NO E-mail address: _____________________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature ________________________________ Date ____/____/____

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature ________________________________ Date ____/____/____

PATIENT INFORMATION ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Name ____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Social Security #____________________ Sex: ☐ Male ☐ Female

ADDRESS:

Mailing Address ____
City *State* *Zip*

Home Phone: ( )__________________ Work Phone: ( )__________________

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

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: ____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address: ____
City *State* *Zip*

Home Phone: ( )__________________ Work Phone: ( )__________________

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:____________________ Phone: ( )__________________ Ext:______

Address of Claim Center:____

____
City *State* *Zip Code*

Name Policy Holder (Insured):______________________________

Insured Date of Birth: ____/____/____ SS#____________________ Sex: ☐ Male ☐ Female

Policy #:____________________ Group Name or #:____________________

Policy Type: ☐ HMO ☐ PPO

Employer Name: ____

Employer Address: ____

If patient is child, check relationship: ☐ Mother ☐ Father ☐ Other____________________

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:____________________ Phone: ( )__________________ Ext:______

Address of Claim Center:____

____
City *State* *Zip Code*

Name Policy Holder (Insured):______________________________

Insured Date of Birth: ____/____/____ SS#____________________ Sex: ☐ Male ☐ Female

Policy #:____________________ Group Name or #:____________________

Policy Type: ☐ HMO ☐ PPO

Employer Name: ____

Employer Address: ____

If patient is child, check relationship: ☐ Mother ☐ Father ☐ Other____________________

Referred by: ______________________________

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)