WRITE LEGIBLY

POLICY AND PATIENT DATA

WRITE LEGIBLY

1. **PAYMENT** is due at the time of service, unless other arrangements have been made.
2. An **INSURANCE CONTRACT** is between the patient and the patient's insurance company; therefore, it is the responsibility of the patient to keep the account current.
3. Patients involved in **LITIGATION** (lawsuits) are, as others, responsibile for their services here at the clinic.
4. We reserve the right to **BILL FOR MISSED APPOINTMENTS**.
5. Personal cleanliness is requested due to the close interpersonal nature of this work.
6. **SMOKING IS PROHIBITED.**

PATIENT NAME			HOME PHONE		WORK PHONE	
STREET ADDRESS			CITY		STATE	ZIP
PREVIOUS ADDRESS	CITY		STATE	ZIP	BY WHOM WERE YOU REFERRED?	
BIRTHDATE	AGE	SOCIAL SECURITY #	DRIVER'S LICENSE #		HEIGHT	WEIGHT
OCCUPATION		EMPLOYER	EMPLOYER'S ADDRESS			
SPOUSE'S NAME		SPOUSE'S BIRTHDATE	SPOUSE'S SOCIAL SECURITY #		SPOUSE'S WORK PHONE	
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER'S ADDRESS			
IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE NOTIFY?			RELATIONSHIP TO PATIENT		DAYTIME PHONE	

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

PATIENT SIGNATURE:	DATE:	WITNESS SIGNATURE:

IF PATIENT IS A MINOR: Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

GUARDIAN SIGNATURE:	DATE:	WITNESS SIGNATURE:

PLEASE ALLOW OUR OFFICE TO PHOTOCOPY ANY INSURANCE CARD(S) YOU LIST BELOW FOR OUR RECORDS.

INSURANCE #1 (PRIMARY)

PRIMARY INSURANCE COMPANY	NAME OF INSURED	EMPLOYER
I.D. NUMBER	RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS	CITY	STATE ZIP

INSURANCE #2 (SECONDARY)

SECONDARY INSURANCE COMPANY	NAME OF INSURED	EMPLOYER
I.D. NUMBER	RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS	CITY	STATE ZIP

INSURANCE #3 (THIRD)

THIRD INSURANCE COMPANY (If any)	NAME OF INSURED	EMPLOYER
I.D. NUMBER	RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS	CITY	STATE ZIP

PLEASE CONTINUE ON BACK

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PREVIOUS ADDRESS		CITY		STATE ZIP	BY WHOM WERE YOU REFERRED?	
BIRTHDATE	AGE	SOCIAL SECURITY #	DRIVER'S LICENSE #		HEIGHT	WEIGHT
OCCUPATION		EMPLOYER	EMPLOYER'S ADDRESS			
SPOUSE'S NAME		SPOUSE'S BIRTHDATE	SPOUSE'S SOCIAL SECURITY #		SPOUSE'S WORK PHONE	
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER'S ADDRESS			
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INSURANCE #1 (PRIMARY)

PRIMARY INSURANCE COMPANY	NAME OF INSURED	EMPLOYER
I.D. NUMBER	RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS	CITY	STATE ZIP

INSURANCE #2 (SECONDARY)

SECONDARY INSURANCE COMPANY	NAME OF INSURED	EMPLOYER
I.D. NUMBER	RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS	CITY	STATE ZIP

INSURANCE #3 (THIRD)

THIRD INSURANCE COMPANY (If any)	NAME OF INSURED	EMPLOYER
I.D. NUMBER	RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS	CITY	STATE ZIP

PLEASE CONTINUE ON BACK

