POLICY AND PATIENT DATA

- 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 | PHOHIB | HED. | | | | | | | |
|--|---|-------------------------|-------------------------|--|-----------------------------|---|------------------|---------------------|--|
| PATIENT NAME | | HOME PHONE | | | WORK PHONE | | | | |
| STREET ADDRESS | | | | CITY | CITY | | | STATE ZIP | |
| PREVIOUS ADDRESS | CITY | 4.00.00 | STATE ZIP | | BY WHOM | WERE YOU REFERRED? | | | |
| BIRTHDATE | AGE | SOCIAL SECURITY # | | DRIVER | 'S LICENSE # | | HEIGHT | WEIGHT | |
| OCCUPATION | CUPATION EMPLOYER | | | EMPLOYER'S ADDRESS | | | | | |
| SPOUSE'S NAME | | SPOUSE'S BIIRTHDATE | | SPOUSE | SPOUSE'S SOCIAL SECURITY # | | | SPOUSE'S WORK PHONE | |
| SPOUSE'S OCCUPATION | | SPOUSE'S EMPLOYER | 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 | N ACKNOWL | EDGEMENT THAT I HA | VE READ THE PO | LICIES AB | OVE AND AGREE TO A | BIDE BY THE S | AME. | | |
| PATIENT SIGNATURE: | | | | TE: | WITNESS SIGNATURE: | | | | |
| IF PATIENT IS A MIN legal guardian. | NOR: Permi | ssion is hereby given t | by me to the doct | ors of this | office and whomever the | hey designate | to treat the pat | ient. I am his/hei | |
| GUARDIAN SIGNATURE: | | | DA I | TE: | WITNESS SIGNATURE: | | | | |
| PLEASE ALLOW | OUR OF | FICE TO PHOTOC | COPY ANY IN | SURAN | CE CARD(S) YOU | LIST BELO | W FOR OUF | RECORDS. | |
| INSURANCE #1 (PR | | | | | : <u>.</u> | | | | |
| | PRIMARY INSURANCE COMPANY | | | SURED | | | EMPLOYER | | |
| I.D. NUMBER | .D. NUMBER | | | IP TO PATIEN | IT (If other than self) | | PHONE | | |
| BILLING ADDRESS | | | CITY | CITY | | | STATE ZIP | | |
| NSIIDANCE #2 (SE | COND ARY) | | | | | *************************************** | _1 | | |
| | NSURANCE #2 (SECONDARY) SECONDARY INSURANCE COMPANY | | | NAME OF INSURED | | | EMPLOYER | | |
| I.D. NUMBER |). NUMBER | | | RELATIONSHIP TO PATIENT (If other than self) | | | PHONE | | |
| BILLING ADDRESS | | | CITY | CITY | | | STATE ZIP | | |
| NSURANCE #3 (TH | IIRD) | | | | | | | | |
| | HIRD INSURANCE COMPANY (If any) | | | NAME OF INSURED | | | EMPLOYER | | |
| I.D. NUMBER | D. NUMBER | | | RELATIONSHIP TO PATIENT (If other than self) | | | PHONE | | |
| BILLING ADDRESS | | | CITY | | | | STATE ZIP | | |

WRITE LEGIBLY

POLICY AND PATIENT DATA



- 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 | |
| | | | | | CTATE TO | | WEST WOLL ST | | |
| PREVIOUS ADDRESS | | CITY | | 1 | STATE ZIP | BA MHOW | WERE YOU RE | :FERRED? | |
| BIRTHDATE | AGE | SOCIAL SECURITY # | | I DRIVER'S | LICENSE # | | HEIGHT | WEIGHT | |
| DITTIONIE | AGE | SCOINE GEODING 7 # | | 0.1172713 | | | , icidin | , real | |
| OCCUPATION | | EMPLOYER | | EMPLOYER'S ADDRESS | | | | | |
| POUSE'S NAME SPOUSE'S BIIRTHDATE | | SPOUSE'S BIIRTHDATE | | SPOUSE'S SOCIAL SECURITY # | | | SPOUSE'S WORK PHONE | | |
| SPOUSE'S OCCUPATION | POUSE'S OCCUPATION SPOUSE'S EMPLOYER | | - | SPOUSE'S EMPLOYER'S ADDRESS | | | | | |
| IN THE EVENT OF AN EME | SHOULD WE NOTIFY? | | RELATIONSHIP TO PATIENT | | | DAYTIME PHONE | | | |
| MY SIGNATURE IS AI | ACKNOWLE | DGEMENT THAT I HAVE | READ THE POLIC | CIES ABO | /E AND AGREE TO A | BIDE BY THE SA | AME. | | |
| PATIENT SIGNATURE: | | | DATE | : | WITNESS SIGNATURE: | | | | |
| | | | 1 | | | | | | |
| F PATIENT IS A MII egal guardian. | NOR: Permis | sion is hereby given by | me to the doctor | s of this o | fice and whomever t | hey designate | to treat the | patient. I am his/her | |
| GUARDIAN SIGNATURE: | | | DATE | : | WITNESS SIGNATURE: | | | | |
| PLEASE ALLOW INSURANCE #1 (PF | | ICE TO PHOTOCO | DPY ANY INS | URANCI | E CARD(S) YOU | LIST BELO | W FOR C | OUR RECORDS. | |
| | PRIMARY INSURANCE COMPANY | | NAME OF INSUR | RED | | | EMPLOYER | | |
| I.D. NUMBER | D. NUMBER | | | RELATIONSHIP TO PATIENT (If other than self) | | | PHONE | | |
| BILLING ADDRESS | | | CITY | *************************************** | | | STATE | ZIP | |
| NSURANCE #2 (SE | COMPARY) | | | | | | <u> </u> | | |
| SECONDARY INSURANCE | | | NAME OF INSU | RED | | | EMPLOYER | | |
| I.D. NUMBER | | | RELATIONSHIP | TO PATIENT | (If other than self) | ······································ | PHONE | | |
| BILLING ADDRESS | | | CITY | | | | STATE | ZIP | |
| NSURANCE #3 (TH | IRD) | | | | | | | | |
| THIRD INSURANCE COMP | | | NAME OF INSUR | RED | | | EMPLOYER | • | |
| I.D. NUMBER | | | RELATIONSHIP TO PATIENT (If other than self) | | | | PHONE | | |
| 211 L HAG ADOSCOS | | | CITY | | | | STATE | ZIP | |
| BILLING ADDRESS | • | | ULT | | | | 1 1 | | |