Confidential Patient Information

Date:_____

Where you referred to a certain doctor in the clinic? Y/N If yes, who? _____
Did you find the doctor on the Blue cross Blue Shield Website? Y/N

Patient Data

Name:_____ Cell Phone:_____
Address:_____ City/State:_____ Zip:_____
Home Phone:_____ Email:_____ Birthday:_____
Emergency Contact/Relationship:_____Phone:_____

Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. IN rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. Furthermore, I understand that this office will submit the forms to the insurance company to assist in collecting from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees and professional services rendered me will be due and payable immediately.

Patient Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____