WELCOME TO OUR OFFICE

Date ____________________

Name of Patient ____________________ Age __________ Sex __________

Address ____________________

City ____________________ State __________ Zip __________

Email ____________________ Date of Birth ____________________

Pharmacy of Choice ____________________ Pharmacy Phone ____________________

Patient Home Phone ____________________ Work Phone ____________________

Any Known Allergies ____________________

EMPLOYER/INSURANCE

Employer ____________________ Occupation ____________________

Name of Spouse/Parents ____________________

Employer ____________________

Insurance Company ____________________

Subscriber ____________________ Policy No. ____________________

Insurance Company ____________________

Subscriber ____________________ Policy No. ____________________

Insurance Company ____________________

NEAREST FRIEND OR RELATIVE NOT LIVING AT SAME ADDRESS

____________________ Relationship ____________________

Address ____________________ Phone ____________________

MEDICAL RECORDS RELEASE (OPTIONAL)

I give my consent to ____________________ Relationship ____________________

to obtain results of my diagnosing testing (excluding HIV/STDs), that have been performed.

Signature ____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

I hereby authorize this office to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or by dependents.
I understand that I am responsible for any amount not covered by insurance.

Signature ____________________ Date ____________________

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