

PATIENT INFORMATION SHEET

PATIENT
NAME _____ BIRTHDATE ____/____/____ AGE _____

ADDRESS _____ S.S. # ____/____/____

CITY/ST/ZIP _____ PHONE _____ EMAIL _____

EMPLOYER _____ PHONE _____

OCCUPATION _____ YEARS _____

SPOUSE NAME _____ BIRTHDATE ____/____/____ S.S # ____/____/____

EMPLOYER _____ PHONE _____

CHILDREN NAME _____ AGE _____ NAME _____ AGE _____

PERSON TO CONTACT (OTHER THAN SPOUSE)
IN CASE OF EMERGENCY _____

PHONE _____ CITY/ST/ZIP _____

IS THIS CONDITION: JOB RELATED? Y N AUTO? Y N

GUARANTEE OF PAYMENT: I HEREBY GUARANTEE PAYMENT OF ALL SERVICES RENDERED. I UNDERSTAND THAT THIS IS NOT CONTINGENT UPON PAYMENT FROM THE INSURANCE COMPANY. I FURTHER AGREE AND UNDERSTAND THAT THE POLICY PROVISIONS ARE A CONTRACT BETWEEN THE INSURANCE COMPANY AND THE POLICY HOLDER, AND THAT I AM RESPONSIBLE TO KNOW ANY POLICY LIMITATIONS THAT MIGHT EXIST.

SIGNATURE _____ **DATE** _____

ASSIGNMENT OF BENEFITS & MEDICAL INFORMATION RELEASE

I HEREBY INSTRUCT AND DIRECT THE INSURANCE PROVIDER TO PAY DIRECTLY TO:

ALL BENEFITS THAT THE POLICY PROVISIONS ALLOW FOR SERVICES RENDERED. IF THE CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE HEALTH CARE PROVIDER, THEN I ALSO INSTRUCT AND DIRECT THE INSURANCE COMPANY TO MAKE THE CHECK PAYABLE TO MYSELF AND MY HEALTH CARE PROVIDER. I FURTHER AUTHORIZE MY HEALTH CARE PROVIDER AND REPRESENTATIVES TO RELEASE ANY INFORMATION REGARDING MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, ATTORNEY, OR BUREAU OF; WORKERS' COMPENSATION AGENT IT DEEMS NECESSARY. I ALSO AUTHORIZE MY HEALTH CARE PROVIDER AND ITS AGENTS AND EMPLOYEES TO ACT ON MY BEHALF IN ALL MATTERS PERTAINING TO MY CARE AND TREATMENT. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER ANY POLICY.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

DATED THE _____ OF _____ 20 _____

SIGNATURE OF POLICY HOLDER / CLAIMANT _____

WITNESS _____

I UNDERSTAND THAT IF I AM ACCEPTED AS A PATIENT BY THE PHYSICIANS OF THIS OFFICE, I AM AUTHORIZING THEM TO PROCEED WITH ANY TREATMENT THAT MAY BE NECESSARY. FURTHERMORE, ANY RISKS REGARDING YOUR TREATMENT WILL BE EXPLAINED TO ME UPON MY REQUEST.

SIGNATURE _____ **DATE** _____