PATIENT INFORMATION SHEET

PATIENT
NAME_____ BIRTHDATE_____/_____/_____ AGE _____

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

CITY/ST/ZIP _____ EMAIL_____

HOME # _____ WORK # _____ CELL # _____

EMPLOYER_____ OCCUPATION _____

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 NECESSSARY, 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. **I ALSO UNDERSTAND THAT I AM LIABLE FOR ANY AND ALL LEGAL AND COLLECTION FEES.**

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** _____