PATIENT INFORMATION FORM

(OFFICE USE ONLY)

PI INSURANCE CASH

Patient File # ___________________ Doctors Name __________________________________

First Name ___________________ M.I ____ Last Name _______________________ Sex ____

Birth Date _____/_____/_____ Age____ Marital Status (S M W D)Spouse____________

Driver's License No. ___________________ State _____

Address ___________________________City_________________State _____ Zip_________

Home Phone ( ) ________________ Cell Phone ( ) _______________________

Employer __________________ Job Title _______________ Work Phone ( )____________

E-Mail____ Referred By ________________

Primary Insurance Co. _______________________

Secondary/ Other Insurance Co. __________________________

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the notice of Privacy Practices an i have been provided an opportunity to review it.

Patient Signature ____________________________________ Date ______/_______/________