PATIENT INFORMATION

Date_____

First Name_____ Last Name_____ Middle Initial_____

Married_____ Single_____ Minor_____ Male_____ Female_____

Social Security #_____ Drivers Lic:_____

Address_____

Birthdate_____Email Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Name of Employer_____ Address_____

If Full Time Student, School Name_____ Grade_____

Person Responsible for Account_____Patient_____Guardian_____Spouse_____Father_____Mother

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured:_____ Relationship to Insured _____

Insured Soc Sec:_____ Insured Birth Date_____

Employer:_____ Insurance Company_____

Address:_____ Address:_____

Address:_____ Address:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured _____

Insured Soc Sec:_____ Insured Birth Date_____

Employer:_____ Insurance Company_____

Address:_____ Address:_____

Address:_____ Address:_____

Person to Contact
In case of Emergency:_____ _____
Name Telephone

Whom may we thank for referring you to our office?_____

Service Charge: If I do not pay the entire new balance within **90** days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of **1.5%** per month (or a minimum charge of **$1.00** for a balance under **$4.00**) which is an annual percentage rate of **18%** applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account for future outstanding accounts.

AUTHORIZATION

_____ _____
Patient or Responsible Party Date