PATIENT INFORMATION SHEET

Patient Name: _____ DOB: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Gender: _____ Email: _____

Home Phone: _____ Can we leave a message at this number? Yes No

Mobile Phone: _____ Can we leave a message at this number? Yes No

Primary Insurance: _____ Phone: _____

Address: _____

Copay: _____ Prior Authorization Needed? Yes No Visit Limit: _____

ID #: _____ Group #: _____

Subscriber Name: _____ DOB: _____

Relationship: _____ SSN: _____ Phone: _____

I certify that I am the person responsible for payment on this account. I understand that it is my responsibility to pay for all services rendered, regardless of whether or not my insurance company pays.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

---------- FOR OFFICE USE ONLY ----------

Notes:

Dx Code 1: _____

Dx Code 2: _____

Dx Code 3: _____