PATIENT DATA SHEET

How did you hear about us? ☐ building sign/driving by, ☐ referral, ☐ website, ☐ yellow pages, ☐ other: Please specify ____

PERSONAL INFORMATION DATE: ___________________________

PATIENT NAME: ____
First Middle Initial Last

ADDRESS: ____

CITY: ______________________________________ STATE: _____________________ ZIP CODE: ________________

HOME PHONE: (_____)________________________ WORK / CELL PHONE: (_____)___________________________

SOC SEC #: __________________________________ DATE OF BIRTH: __________________ GENDER: _____

MARITAL STATUS: S M D W EMPLOYER: ____

OCCUPATION: ______________________________ REFERRED BY: ____

EMERGENCY CONTACT NAME : ________________________ RELATIONSHIP: ____

PHONE #: ____

EMAIL ADDRESS: ____

RESPONSIBLE PARTY INFORMATION / NAME OF INSURED

NAME: ____
First Middle Initial Last

ADDRESS: ____

CITY: ______________________________________ STATE: _____________________ ZIP CODE: ________________

HOME PHONE: (_____)________________________ ALTERNATE PHONE: (_____)___________________________

SOC SEC #: __________________________________ DATE OF BIRTH: __________________ GENDER: _____

EMPLOYER: _________________________________ OCCUPATION: ____

CONSENT TO TREAT

I hereby authorize consent for ____ (clinic/doctor), to provide medical care and treatment.

PRINT: _________________________ SIGN: ________________________________DATE: __________________
Patient Patient

PRINT: _________________________ SIGN: ________________________________DATE: __________________
Patient or Legal Guardian Patient or Legal Guardian

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorized and request my insurance company to pay directly to ______________(clinic), insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents.

PRINT: _________________________ SIGN: ________________________________DATE: __________________
Patient Patient

PRINT: _________________________ SIGN: ________________________________DATE: __________________
Patient or Legal Guardian Patient or Legal Guardian