PATIENT INFORMATION FORM

First Name _____ Last Name _____ Preferred Name _____ Gender _____

Street Address _____ City _____ State _____ Zip _____

Last 4 digits of SSN _____ Date of Birth _____ Email Address _____

Cell Phone _____ Work Phone _____ Home Phone _____

Primary Care Doctor and Location _____ Pharmacy Name and Location _____

Primary Medical Insurance Information

Insurance Name _____ Policy/ID Number _____ Subscriber Name _____

Patients Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Medical Insurance Information

Insurance Name _____ Policy/ID Number _____ Subscriber Name _____

Patients Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Vision Insurance Information

Insurance Name _____ Policy/ID Number _____ Subscriber Name _____

Patients Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:
I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. There will be a charge on all returned checks. Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

Patient Signature _____ **Date** _____

_____ _____

Parent/Guardian Name if Applicable **Parent/Guardian Date of Birth**