

INFORMATION FORM

BY PROVIDING THIS INFORMATION, I AUTHORIZE YOU TO GIVE REASONABLE AND PROPER CARE BY TODAY'S STANDARDS

Child/Patient: _____ Date: _____
(Last) (First) (Middle)

Birthdate: _____ Sex _____ Preferred Phone: _____ Other Phone: _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

E-mail Address: _____

Has any member of your family been seen at this clinic before? _____ If yes, please list names and dates of birth.
No Yes

(Last Name) (First Name) (DOB)

Person Responsible for Fees: _____
(Last) (First) (Middle)

Social Security Number: _____ Relationship to Client _____ Telephone Number _____

Billing Address: _____
(If different) (Street/P.O. Box) (City) (State) (Zip)

Employer's Name: _____ Phone: _____

Insurance Company: _____
(Name) (Billing Address)

Name of Subscriber: _____ DOB: _____ Relationship to Client: _____

Group #: _____ Identification #: _____

Address of Subscriber (if different) _____

Referring Doctor/Agency: _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Client's Primary Physician: _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

This form MUST be filled out COMPLETELY and received prior to your first appointment. A health insurance card MUST be presented at the first appointment.

Federal Law requires verification of the identity/address of the patient, patient, person responsible for fees, and insurance subscriber. Please be prepared to provide these documentation with a PHOTO ID with an address or alternate documentation of address at check-in.

Verification of: Patient Guarantor Insurance Subscriber