

Patient-Minor		Male	Female	Do you reside with guarantor?		Yes	No
Full Name		DOB	Age	Social Security No.			
Mailing Address			Email		Home Phone		
LEGAL PARENT OR	DOB:	Male	Female	Social Security No.			Years in area
Mailing Address			Driver Lic #	Relationship to Patient			
Street Address			Years at this address	Home Phone			
Previous Address If less than 2 yrs at above address				Email:	Years at Previous Address		
Employer & Emp Address				Work Phone			
Length of Employment	Yrs	Position		Name of Supervisor			
Do you own your own home? Yes No		If no, Name & Phone No of Landlord					
Do you have	Yes	Have you ever had a bill Sent to a collection agency	Yes No	If yes, is it now paid in full?	Yes No	Have you ever Declared bankruptcy?	Yes No Date:
						Have you every had Property repossessed?	Yes No
OTHER PARENT OR GUARDIAN		DOB:	Male	Female	Social Security No.		
Full Name				Driver Lic #			
Mailing Address				Do you reside with guarantor? Yes No			
Employer & Emp Address				Work Phone			
Medical Insurance Information		We request that deductibles and co-payments be paid at the time of service.				Type of Policy: Group Private HMO OR Health Plan	
Primary Insurance Name & Address							
Group No: Member No			Deductible:		CoPay:		
Are any of the following required?		Referral from primary care physician		Prior authorization		We do not file secondary insurance. We need the information on file to respond to inquiries.	
Secondary Insurance				Name of Policyholder			
Group No: Member No			Deductible:		CoPay:		
Are any of the following required?		Referral from primary care physician		Prior authorization		Type of Policy: Group Private HMO OR Health Plan	
Referring Physician				PCP			
Emergency Name, Address & Phone #					Relationship to Patient		
<p>Regulation Z of the Federal Truth in Lending Act requires us to state that we operate on a payment at time of visit basis When granted, credit is extended to approved applications on the following terms only: Each patient will have the option to make payment in full within 30 days or make monthly installments in the amount determined by the scheduled outlined in our Office Policy (approximately 10% of the unpaid balance). All accounts are subject to a finance charge of ten percent (10%) a year or 0.8333 percent per month on any balances outstanding for 90 days or more.</p> <p>I agree to the above terms and to pay finance charge of 10% per year on balances outstanding 90 days or more. I understand and agree that if it becomes necessary to turn this matter over for collection, the prevailing party shall be entitled to recover reasonable costs including attorney fees together with interest as provided by law on all amounts found due for professional services.</p> <p>I authorize the release of any medical information necessary to process any insurance claim for professional services received.</p> <p>I have read the Office Policy and agree to the provisions contained therein.</p>							
Date:		Signature					
<p>I do not wish credit. I will pay charges in full the same day I see the Doctor.</p> <p>Date: _____ Signature _____</p>							
<p>Consent to Treatment: I consent to treatment as necessary or desirable for the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operation and conduct of laboratory, x-ray or other studies that may be used by the attending Medical Doctor or qualified designate. It is my understanding that the need for each test, medication and surgical procedure will be fully explained.</p>							

