

Patient			Male	Female	Civil Status: Single	Married	Widowed	Divorced	Email:
Full Name			DOB		Age		Social Security No.		
Mailing Address							Home Phone		
Employer & Emp Address							Work Phone		
Supervisor's Name			Length of Employment		Position		Driver Lic #		Do you live with Responsible party? Yes No
Is this illness job related? Yes No Undecided		Has a Workman's Compensation Claim been filed? Yes No			Date Filed		Claim Number		Where filed
Responsible Party			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							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 A major credit card Yes No		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	
Spouse of Responsible Party			DOB: Male Female		Social Security No.				
Full Name							Driver Lic #		
Employer &							Work		
Medical Insurance Information			Is any of the following required: Referral from PCP Prior Authorization			Type of Policy: Group Private HMO OR Health Plan Other: List			
Primary Insurance						Deductible		CoPayment	
Group No: Member No					Name of Policyholder				
Secondary Insurance Name & Address							We do not file secondary insurance. We need the information on file to respond to inquiries.		
Group No: Member No					Name of Policyholder				
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>									
<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>									

