

PATIENT INFORMATION SHEET

Patient's Name _____
Residence – Street _____
City _____ State _____ Zip _____
Home Telephone _____
Date of Birth _____ / _____ / _____ Age _____

Name of Referring Doctor _____
Patient's Social Security Number _____
Patient Employed By _____
Employer Address _____
City _____ State _____ Zip _____
Business Telephone _____
Patient's Dental Insurance Co. _____
Patient's Medical Insurance Co. _____

Spouse's Name _____
Spouse's Social Security Number _____ Birthdate ____ / ____ / ____
Spouse Employed By _____
Employer Address _____
City _____ State _____ Zip _____
Business Telephone _____
Spouse's Dental Insurance Co. _____
Spouse's Medical Insurance Co. _____

Charges and Payments Explanation

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of the insurance coverage. Should my insurance not cover all my fees, I will remain responsible for the remaining balance and agree to pay in full 90 days from service date. If no insurance coverage, it is customary to pay for services when rendered unless other arrangements have been made in advance.

Authorization To Pay Physician

I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits. I understand that I am financially responsible for the charges not covered by this authorization.

Authorization To Release Information

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to my insurance company.

Patient's Signature _____ **Date** _____

***** **COMPLETE BOTH SIDES OF THIS SHEET** *****

