

## Patient Information Sheet

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Gender: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Can we leave a message at this number? Yes No

Mobile Phone: \_\_\_\_\_ Can we leave a message at this number? Yes No

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Copay: \_\_\_\_\_ Prior Authorization Needed? Yes No Visit Limit: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that I am the person responsible for payment on this account. I understand that it is my responsibility to pay for all services rendered, regardless of whether or not my insurance company pays.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

----- FOR OFFICE USE ONLY -----

Notes:

Dx Code 1: \_\_\_\_\_

Dx Code 2: \_\_\_\_\_

Dx Code 3: \_\_\_\_\_