INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**

Today's Date_______________________________
Name____________________________________ Home Phone #_________________________
Work Phone #______________________________ Cell Phone #__________________________
Address___________________________ City_________________ State________ Zip ______
Age ________ Birthdate _____________ Marital Status: S M W D No. of Children ______

Your Employer______________________________ Occupation___________________________
Employer's Address _________________________ City__________ State _______ Zip _____

Insurance Company __________________________ Your Social Security # _______________
Insurance Company's
Address.____
I.D. #______________________________________ Group #______________________________
Name of Spouse or Parent (If child) _________________________ Birthdate _______________
Spouse's Employer ___________________________ Occupation___________________________
Employer's Address ___________________________ City_________ State _______ Zip ______
Spouse's Social Security # _____________________

Who referred you to our office?____
Were you referred to a certain doctor in this office?______________________________________

Is your condition due to an accident?____________ Date of Accident ______________________
Type of accident? Auto_______ Work/On Job_______ At home__________ Other__________
Have you ever been in a car accident? Yes___ No___ When? ___________________________

Please circle payment type you plan to use for today's visit Cash Check Credit/Debit card

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's (Parent or Guardian's) Signature ____
Date ______________________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangement should be made in advance before seeing the doctor.