PATIENT INFORMATION

TODAY'S DATE

_____ _____ _____
Month Day Year

NAME:

_____ _____
First Name Last Name

DATE OF BIRTH

_____ _____ _____
Month Day Year

YOUR AGE:

_____

SOCIAL SECURITY #

_____

MARITAL STATUS

- ❑ MARRIED
- ❑ SINGLE
- ❑ DIVORCED
- ❑ WIDOW(ER)

MAILING ADDRESS

_____
Street Address

_____
Street Address Line 2

_____ _____
City State / Province

_____ **0**
Postal / Zip Code Country

YOUR E-MAIL

_____

HOME PHONE

_____ _____
Area Code Phone Number

WORK PHONE

Area Code _____ Phone Number _____

CELL PHONE

Area Code _____ Phone Number _____

OCCUPATION _____

EMPLOYER _____

EMERGENCY CONTACT OTHER THAN SPOUSE

Area Code _____ Phone Number _____

RELATIONSHIP _____

PHONE NUMBER

Area Code _____ Phone Number _____

REFERRED BY WHOM _____

INSURANCE

PRIMARY _____

PRIMARY CONTRACT # _____

GROUP # _____

INSURED'S NAME _____

RELATIONSHIP TO PATIENT

_____

INSURED'S DOB

Month _____ Day _____ Year _____

SECONDARY INSURANCE _____

SECONDARY CONTRACT # _____

GROUP # _____

INSURED'S NAME _____

THIS UNDERSIGNED HEREBY CONSENTS TO CARE AND TREATMENT NOW AND IN THE FUTURE IN THE EVENT MY INSURANCE COMPANY IS BILLED. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED. IF MY INSURANCE COMPANY IS NOT BILLED OR FAILS TO PAY MY CLAIM IN FULL, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF CHARGES FOR SERVICES RENDERED. I UNDERSTAND IF MY ACCOUNT BECOMES DELIQUENT, I AM RESPONSIBLE FOR OUTSIDE COLLECTION/ATTORNEY FEES. I UNDERSTAND IT IS MY RESPONSIBILITY TO VERIFY BENEFITS WITH MY INSURANCE COMPANY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM.

I GIVE DR. BATEMAN'S OFFICE CONSENT TO REQUEST ANY MEDICAL RECORDS FROM ANY OTHER SOURCE THAT MAY BE HELPFUL IN MY TREATMENT PLAN.

Patient's Signature_____