PERSONAL INFORMATION FORM

PATIENT PERSONAL IDENTIFICATION

First Name: ________________________ M: _____ Phone #: (h) ____________ (c) ____________

Last Name: ________________________ Birth Date: ________________________

Address: ________________________________ Gender: ________ Male ________ Female

City, St, Zip: ________________________________ Social Security Number: ____________

Email: ________________________________

RESPONSIBLE PARTY (if other than above)

First Name: ________________________ Phone #: (h) ____________ (c) ____________

Last Name: ________________________ Email : ________________

Address: ________________________

City, St, Zip: ________________________

ADDITIONAL RESPONSIBLE PARTY

First Name: ________________________ Phone #: (h) ____________ (c) ____________

Last Name: ________________________ Email : ________________

Address: ________________________

City, St, Zip: ________________________

BILLING INFORMATION

Which of the following will contribute to paying the bill.

☐ Primary Insurance Company will pay through reimbursement.

☐ Responsible party will pay the fee for services: $ ______.

INSURANCE COMPANY INFORMATION (Complete only if you intend to submit billing statements)

Ins. Co. Name: ________________ Ins. Co. Authorization Phone: ________________

Address: ________________________________

City, St, Zip: ________________________________

Policy Holder

First Name: ________________________ ID Number: ________________________

Last Name: ________________________ Policy #: ____________ Group #: ____________

Address: ________________________________ Gender: ______ Male _______ Female

City, St, Zip: ________________________________ Birth Date: ________________