Patient Information Form
Child

Child's Name_____ Date of Birth_____

Parent Name_____ Hm #_____ WK#_____

Cell #_____ Email Address_____

Home Address_____ City_____ Zip Code_____

SS#_____ Occupation_____ Employer_____

Employer Address_____ Employer Phone_____

Date Of Birth_____ Single Married Widowed Divorced_____

Spouse Name_____ Birthday_____ SS#_____

Spouse Occupation _____ Spouse Employer_____
In case of Emergency Please Contact (someone not living with you)
Name_____ Relationship to you_____
Address and Phone # of Contact _____
Whom may we thank for referring you?_____
Who is responsible for this account_____

Insurance Company_____ Group #_____
Subscriber's Name_____ Subscriber's Birthday_____
Subscriber's SS#_____

I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered and any missing appointment fees. All delinquent accounts will be charged interest at the rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 33% of the unpaid balance. In the event legal action becomes necessary to collect the unpaid balance, the undersigned further agrees to pay all reasonable attorneys fees and court costs.
I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature_____ Date_____