PATIENT DATA SHEET

PERSONAL INFORMATION DATE: _____

PATIENT NAME: _____
First Middle Initial Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____)_____ WORK / CELL PHONE: (_____)_____

SOC SEC #: _____ DATE OF BIRTH: _____ GENDER: _____

MARITAL STATUS: S M D W EMPLOYER: _____

OCCUPATION: _____ REFERRED BY: _____

EMERGENCY CONTACT NAME : _____ RELATIONSHIP: _____

PHONE #: _____

EMAIL ADDRESS: _____

RESPONSIBLE PARTY INFORMATION / NAME OF INSURED

NAME: _____
First Middle Initial Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____)_____ ALTERNATE PHONE: (_____)_____

SOC SEC #: _____ DATE OF BIRTH: _____ GENDER: _____

EMPLOYER: _____ OCCUPATION: _____

CONSENT TO TREAT

I hereby authorize consent for _____ (clinic/doctor), to provide medical care and treatment.

PRINT: _____ SIGN: _____DATE: _____
Patient Patient

PRINT: _____ SIGN: _____DATE: _____
Patient or Legal Guardian Patient or Legal Guardian

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorized and request my insurance company to pay directly to _____(clinic), insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents.

PRINT: _____ SIGN: _____DATE: _____
Patient Patient

PRINT: _____ SIGN: _____DATE: _____
Patient or Legal Guardian Patient or Legal Guardian