Patient Information Form (Please Print)

PATIENT INFORMATION

Date ______________________ Age __________ Date of Birth __________________ Sex ☐ M ☐ F

Patient Last Name ________________________ First Name ________________________ Middle Initial _____

Home Address ________________________ City ____________________ State _____ Zip ________

Social Security # ______________ Employer ______________________ Occupation __________________

Home Phone # (____) ____ - ______ Cell Phone # (____) ____ - ______ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Work Phone # (____) ____ - ______ E-mail ____________________ ☐ Separated ☐ Divorced ☐ Partner

Do you have a legal guardian or healthcare power of attorney? Yes No

If yes, Name __________________________ Relationship __________________ Phone # (____) ____ - ______

Emergency Contact ______________________ Relationship __________________ Phone # (____) ____ - ______

Primary Care Doctor ____________________________ Phone # (____) ____ - ______

Pharmacy ___________________________ Location ______________ Phone # (____) ____ - ______

Who is responsible for payment? ________________________ Relationship to patient? ________________

Address ________________________ City/State ________________ Zip ______ Phone # (____) ____ - ______

Social Security # ____________________

INSURANCE INFORMATION

Primary Insurance Company Name ____

Employer's Name ______________________________ Member ID # ______________________

Subscriber's Name ______________________________ Group # ______________________

Subscriber's Date of Birth ____________________________

Secondary Insurance Company Name ____

Employer's Name ______________________________ Member ID # ______________________

Subscriber's Name ______________________________ Group # ______________________

Subscriber's Date of Birth ____________________________

PAYMENT AGREEMENT

I hereby authorize the release of medical information such as may be deemed necessary to expedite my claim. I hereby authorize payment directly to Dr. Brittany Jones / Dr. Jeffrey Crowhurst. I understand that I am responsible for charges that are not covered by my insurance.

______________________________ ______________

Responsible Party Signature Date

LEGAL NOTICE / DISCLAIMER: The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.