



**Patient Information Record**

Please Print

**Patient Name** \_\_\_\_\_ Age \_\_\_\_\_ Gender M F

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Middle Initial

Email Address \_\_\_\_\_ Marital Status S M W D Sep

Street Address \_\_\_\_\_  
City State Zip

**Employer** \_\_\_\_\_ Occupation \_\_\_\_\_ How Long \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

**Primary Doctor** \_\_\_\_\_ Phone \_\_\_\_\_

Primary Doctor Address \_\_\_\_\_  
City State Zip

**Referred by** \_\_\_\_\_

**Nearest relative** \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

**Spouse** (or Parent, if minor) \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Phone \_\_\_\_\_  
Last First Middle Initial

Street Address \_\_\_\_\_  
City State Zip

**Employer** \_\_\_\_\_ Occupation \_\_\_\_\_ How Long \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

**Primary Insurance Company** \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

ID# \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_\_

Policyholder's Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

Policyholder's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_  
City State Zip

**Other Insurance Company** \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

ID# \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_\_

Policyholder's Address \_\_\_\_\_ Phone \_\_\_\_\_  
City State Zip

Policyholder's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_  
City State Zip

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date