Patient File Form A

Please print before filling in.
This is a confidential record and will be kept in your doctor's office and will not be released to anyone without your prior authorization.

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DATE_____/_____/_____

LAST NAME_____FIRST_____MI____

ADDRESS_____

CITY_____ STATE_____ZIP_____
(CIRCLE ONE)

SS#_____DOB_____ __MALE FEMALE _____AGE_____

TELEPHONE
(HOME)_____(WORK)_____(CELL)_____

PRIMARY CARE PHYSICIAN_____

REFERRING PHYSICIAN_____

EMPLOYER_____OCCUPATION_____

PLEASE INDICATE IF MESSAGES CAN BE LEFT OR MAIL SENT

HOME PHONE _____YES_____NO _CELL_____YES_____NO

WORK PHONE _____YES_____NO HOME ADDRESS_____YES_____NO

NAME AND ADDRESS OF PARENT OR GUARDIAN:_____

**********INPORTANT NOTICE!!!**********

I FULLY UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN A REFERRAL/AUTHORIZATION FOR THIS VISIT IF IT IS REQUIRED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE. I GIVE THIS OFFICE PERMISSION TO RELEASE ANY INFORMATION OBTAINED DURING EXAMINATION OR TREATMENTS OF THIS PATIENT THAT IS NECESSARY TO SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT AND SECURE TIMELY PAYMENTS DUE TO ASSIGNEE OR MYSELF.
I HEREBY ASSIGN MEDICAL BENEFITS, INCLUDING THOSE FROM GOVERNMENT SPONSORED PROGRAMS AND OTHER HEALTH PLANS TO BE PAID TO THE PARTY WHO ACCEPTS ASSIGNMENT A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS GOOD AS THE ORIGINAL.

_____ _____
CLIENT'S (OR PARENT/GUARDIAN'S) SIGNATURE, INDICATING AGREEMENT TO ALL THE STATEMENTS ABOVE — DATE

_____
PRINT NAME