2017 – PT UPDATE:

Date: _____

(Please Print Clearly)

Name _____
Last First Middle Initial

Date of Birth ___ / ___ / ___ Sex: M F SS# _____ / _____ / _____

Address _____ Home Phone _____

_____ Cell Phone _____

INSURANCE INFORMATION:

Primary INS _____ Member ID# _____

* Policy Holder _____ Relationship to patient _____

Date of Birth _____ / _____ / _____ SS# _____ / _____ / _____

Employer _____

* Secondary INS _____ Member ID# _____

I have provided a copy of the front and back of my insurance card for payment purposes X _____
Insured's Initials

Individuals that I approve to share information with:

Name	Relationship to patient	Phone #
_____	_____	_____
_____	_____	_____

Primary Care Physician _____ May we communicate with PCP? Yes / No

Credit Card information to be on file –

Name as appears on card: _____

_____ _____ _____ _____ Expiration ____ / ____ Security Code _____

As a reminder –

I am aware that should I cancel under 24 hours prior to an appointment, and/or No show, there is a fee that is my responsibility and is not billable to my insurance. X _____
Patient's Initials

Should I request medication refills in between appointments, I understand there is a $20 fee for this service . X _____
Patient's Initials

I AUTHORIZE & ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT

X _____