PATIENT INFORMATION

_____ _____ _____ _____

Last Name First Name Middle Initial Marital Status

_____ _____ _____ _____

Street Address City State Zip Code

(____)_____-_____ (____)_____-_____ (____)_____-_____ _____

Home Phone Cell Phone Work Phone Email Address

Preferred method of contact:
□ Home □Cell Phone □Work □Text Message □Email

Best Day to contact:
□Mon □Tue □Wed □Thu □Sat

Best time to contact:
□AM □PM

If you would like to receive appointment reminders by text message please provide us with your cell phone number and send CSVMI via text to 622622

*Message **and date rates may apply. Text HELP to 622622 for help or STOP to 622622 to opt-out**

_____/_____/_____ _____ _____/_____/_____ _____ □ Male □ Female

Date of Birth Age Social Security Number How did you hear about our office?

Person Responsible for Billing (If patient is a minor)

_____ _____ _____/_____/_____

Last Name First Name Date of birth

_____ _____ (____)_____-_____

Emergency Contact Relationship Emergency Contact Phone

Please note that we are required by federal mandate to ask the following questions. We apologize to any patient that may be offended by the questions below.

Race: □Decline to answer □African American □ Caucasian □ Asian □ Other _____

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Other _____

Preferred Language: □ Decline to answer □ English □ Spanish □ Other _____

Acknowledgement of Financial Policy

Due to rapid changes in insurance company policies and privacy regulations, it is not always possible for us to accurately obtain or confirm your benefits, deductibles and copays. It is ultimately your responsibility to be aware of your contract benefits. Please feel free to inquire if you have any questions.

Patient or Guardian Initials: _____ Date: _____/_____/_____

Please also note that due to HIPAA (Health Insurance Portability and Accountability Act) and other federal regulations, we require that you review our financial policy prior to signing it.

Patient or Guardian Initials: _____ Date: _____/_____/_____

A 1.5% per month late fee will be applied on the amount of any account 30 days past due.

There will be a $25 fee charged for all returned checks.

Patient or Guardian Initials: _____ Date: _____/_____/_____