PATIENT INFORMATION FORM

NAME:_____HOME PHONE:_____WORK PHONE:_____

ADDRESS:_____CITY_____ZIP CODE_____

SPOUSE'S NAME (if applicable)_____WORK PHONE_____

NEAREST RELATIVE NOT LIVING WITH YOU_____PHONE_____

PHYSICIAN_____PHONE_____

WHOME WERE YOU REFERRED TO US BY?_____

SOC. SECURITY #_____DATE OF BIRTH_____

I WILL BE PAYING TODAY BY: CASH_____ CHECK_____ CREDIT CARD_____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have completed the above answers. I certify that this information is true and correct to the best of my knowledge, and will notify you of any changes regarding the above information.

Signature_____Date_____

Parent (if minor)_____ Date_____

HEALTH INSURANCE INFORMATION (for insurance submission)

Insured's ID Number:_____ Insured' Group Number:_____

Insured's Name:_____ Address:_____

Insured's Phone Number:_____ Insured's Date of Birth:_____ Sex:_____

Insured' Employer:_____ Insurance Plan Name:_____

Patient's Name:_____ Address:_____

Patient's Phone Number:_____ Patient's Date of Birth _____Sex:_____

Patient's Relationship to Insured: Self_____ Spouse_____ Child _____ Other_____

Patient Status: Single _____ Married _____ Other _____ Employed _____ Full-time Student _____ Part-time Student _____

Is Patient's Condition Related to: Employment _____ Auto Accident _____ Other Accident _____

Insurance Benefits Phone Number:_____ Is there another Health Benefit Plan? Yes _____ No _____

SECONDARY INSURANCE INFORMATION:
Insured's Name: _____ ID #_____ Group #_____

Other Insured's Date of Birth:_____ Sex:_____ Insurance Plan Name:_____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Rost & Associates for services rendered.

Signed_____ Date_____