PATIENT INFORMATION

Social Security # _____ - _____ - _____

Patient Full Name _____ Sex ☐Male ☐Female

Home Address _____

City _____ State _____ Zip _____

Home Phone Number (_____) _____ May we call this #? Y N May we leave a message? Y N

Cellular Phone Number(_____) _____ May we call this #? Y N May we leave a message? Y N

Date of Birth _____ / _____ / _____ Age _____ Marital Status: ☐Married ☐Single ☐ Divorced ☐ Widowed

Student? ☐ NO ☐ YES, where: _____ ☐Full-Time ☐Part-Time

Place of Employment _____ ☐Full-Time ☐Part-Time ☐ Retired

Work Phone Number (_____) _____ May we call this #? Y N May we leave a message? Y N

Whom may we thank for referring you? _____

Primary Care Physician _____ Physician Phone (_____) _____

ARE YOU COVERED BY MEDICAL INSURANCE? ☐ **YES**, complete next section(s) -or- ☐ **NO**, I am Self-Pay

PRIMARY INSURANCE INFORMATION

DO YOU HAVE A COPAY? YES ☐ NO☐ AMOUNT $_____

Name of Insurance Company _____

Address of Insurance Company _____

City _____ State _____ Zip _____

Phone Number (_____) _____

Policy # _____ Group # _____

Name of Policy Holder _____

Relationship to Patient _____

Policy Holder's Social Security # _____ - _____ - _____

Policy Holder's Birthday _____ / _____ / _____

Policy Holder's Employer _____

SECONDARY INSURANCE INFORMATION

DO YOU HAVE A COPAY? YES ☐ NO☐ AMOUNT $_____

Name of Insurance Company _____

Address of Insurance Company _____

City _____ State _____ Zip _____

Phone Number (_____) _____

Policy # _____ Group # _____

Name of Policy Holder _____

Relationship to Patient _____

Policy Holder's Social Security # _____ - _____ - _____

Policy Holder's Birthday _____ / _____ / _____

Policy Holder's Employer _____

SEND STATEMENTS TO: Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ **PHONE** _____

RELATIONSHIP TO PATIENT _____

IT IS IMPORTANT THAT ALL INFORMATION BE COMPLETE. ANY BLANK AREAS WILL CAUSE A DELAY IN PROCESSING YOUR CLAIM. PLEASE BRING YOUR INSURANCE CARD(S) AND THIS FORM TO THE RECEPTIONIST AFTER COMPLETION.

ASSIGNMENT and RELEASE

I hereby authorize Dr. Katherine Jackson to release all necessary information to secure the payment of benefits to my insurance carrier concerning my illness and treatments. I hereby assign the physician all payments for services rendered to myself or my dependents. I understand that I am financially responsible for any services rendered to myself or dependents regardless of any insurance claims. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

SIGNATURE RELATIONSHIP TO PATIENT DATE

TREATMENT CONSENT

I hereby request treatment and care, and I agree to pay for such treatment.

_____ _____ _____

SIGNATURE RELATIONSHIP TO PATIENT DATE