Patient Information Form

Patient Name: (Last)_____(First)_____(MI)____

Nickname/ Preferred Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____Mobile: _____

Birthdate: _____Age: _____Sex: ☐ Male ☐ Female

Country of Birth: _____ Country of Parents' Birth: _____

Social Security Number: _____

Education (check highest level completed):
☐ High School Diploma ☐ 2-Year College ☐ Bachelor's Degree ☐ Graduate Degree

Employment Information:

Employer: _____ Occupation: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Phone (Work): _____Ext. _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Financial Policy:

Thank you for selecting Dr. _____ for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and checks.

By signing below, you agree that you have read and understand all of the above and have agreed to these statements. Should this account be referred to an agency or an attorney for collection, you agree that you will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date