PATIENT INFORMATION SHEET

PATIENTS NAME: ______________________________
FIRST M.I. LAST

Address: ______________________________ Apt/Unit: __________

City: ______________________________ State: __________ Zip Code: ______________

Home Phone: (   ) __________________ Cell Phone: (   ) __________________ ❑ Female ❑ Male

Birthdate: ______________________ Social Security #: __________ - ________ - ____________
MO DAY YEAR

Employer: ______________________________ Business Phone: (   )______________

RESPONSIBLE PARTY: ______________________________ Best Contact #: (   )______________
IF SAME AS PATIENT, WRITE "SAME"

Address: ______________________________ Apt/Unit: __________

City: ______________________________ State: __________ Zip Code: ______________

EMERGENCY CONTACT (person we may contact in case of an emergency not living in your household):

______________________________(   )______________
FIRST NAME LAST NAME RELATIONSHIP PHONE NUMBER

REFERRED BY: ______________________________(   )______________
LAST NAME FIRST NAME PHONE NUMBER

______________________________(   )______________
STREET ADDRESS CITY, STATE FAX NUMBER

PRIMARY PHYSICIAN: ______________________________(   )______________
LAST NAME FIRST NAME PHONE NUMBER

______________________________(   )______________
STREET ADDRESS CITY, STATE FAX NUMBER

INSURANCE INFORMATION:

Primary Insurance: ______________________________ Subscriber Birthdate: ______________

Subscriber Name: ______________________________ Patient Relationship: ______________
FIRST NAME LAST NAME SELF / SPOUSE / CHILD?

Second Insurance: ______________________________ Subscriber Birthdate: ______________

Subscriber Name: ______________________________ Patient Relationship: ______________
FIRST NAME LAST NAME SELF / SPOUSE / CHILD?

PLEASE READ THE FOLLOWING CAREFULLY

Assignment, Release and Financial Agreement: I authorize treatment to the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I am financially responsible for payment purposes, and for a billing fee. Balances over 50 days may incur a billing fee of 1% per month (12% PAR), (RCW19.52), with a minimum charge of $25.00 monthly. I have also been informed of the $25.00 fee (per RCW62A3-515 & 520) on checks returned to NSF. In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing costs and any other costs the court determines proper.

______________________________ ______________________
PATIENT SIGNATURE DATE

Revised: 2/1/2007