Patient Information

Patient Name:_______________________________________ Today's Date: ___________

Last First MI (Preferred Name)

Gender: _______________Birth Date: _______________SS# ____________________

Phone (Home): ____________ (Work): ____________Ext:____Cell:____________E-mail__________________

Address: ____

Street Apartment #

____

City State Zip Code Employer

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________________

Birth Date: ______________**SS#**______________Employer____________________

Phone (Home): ______________ (Work): ____________ Ext: ____ Cell: ___________ E-mail:____________

Address: ____

Street Apartment #

____

City State Zip Code

Insurance Information

Primary

Name of Insured: ________________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _______________ ID #: ___________________ Group #: ___________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

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Financial Agreement

We will work directly for you and will do our best to honor Jesus Christ through our daily work. We will try to provide you with the care you desire when you are ready to do it. We should agree to the treatment plan in advance and will try to be sensitive to your budget and scheduling needs. Payment is expected in full at the time treatment is rendered. We will file your claim for you, so that the insurance company can reimburse you. When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number.

_______________________________ Date_________

Patient or Guardian