PATIENT INFORMATION FORM

Patient's Last Name _____ First Name _____ MI _____

Patient's Address _____ Apt. # _____ PO Box _____

City _____ State _____ Zip Code _____

Mailing Address (If different) _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Patient's Age _____ Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

White ☐ African American ☐ Asian ☐ Indian ☐ Hispanic/Latino ☐

EMPLOYMENT & STUDENT INFORMATION

Are you employed? Full time Part time Are you retired? Yes No Are you a student? Yes No

Patient's Employer _____ Work Phone _____

Patient's Occupation _____ Sit at job? Y / N Stand at Job? Y / N Walk at job? Y / N

INSURANCE INFORMATION

Primary Insurance Company _____ Subscriber's Name _____

Relationship to Insurance Policy Holder _____ Subscriber's DOB _____

Secondary Insurance Company _____ Subscriber's Name _____

Relationship to Insurance Policy Holder _____ Subscriber's DOB _____

RESPONSIBLE PARTY OR EMERGENCY CONTACT INFORMATION

Emergency Contact or Responsible Party _____

May we talk to this person regarding your medical concerns if we can not reach you? Y / N

May we leave a message at your home or cell phone regarding appointments? Y / N

OTHER INFORMATION

How did you hear about our office? _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE REQUIRED BELOW

I, the undersigned, certify that I (or my dependent) have current insurance coverage with the above carriers and assign directly to Drs. David Lawrence, Debra Lawrence, Matthew Lawrence & Michal Szpara all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize this office to administer such treatments and perform such procedures necessary or advisable in the diagnosis and treatment of the undersigned or designated patient. I have been offered a HIPPA Privacy Policy Notice.

I have read the office policy on missed appointments and understand that I am responsible for a $50 fee for appointments that are scheduled and not cancelled within a 24 hour notice.

SIGNATURE _____ **DATE** _____