

PATIENT INFORMATION / CONTACT AUTHORIZATION

FATHER'S INFORMATION

LAST NAME _____ FIRST _____ MIDDLE INITIAL _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 HOME PHONE _____ CELL PHONE _____
 EMPLOYER _____ OCCUPATION _____ WORK PHONE _____
 SOCIAL SECURITY NO. _____ BIRTHDATE _____
 INSURANCE CARRIER. _____ PRIMARY SECONDARY
 PARENT'S MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

MOTHER'S INFORMATION

LAST NAME _____ FIRST _____ MIDDLE INITIAL _____
 MOTHER'S MAIDEN NAME _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 HOME PHONE _____ CELL PHONE _____
 EMPLOYER _____ OCCUPATION _____ WORK PHONE _____
 SOCIAL SECURITY NO. _____ BIRTHDATE _____
 INSURANCE CARRIER _____ PRIMARY SECONDARY
 PARENT'S MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

WHAT IS YOUR PREFERRED WAY TO BE CONTACTED: (Circle All that Apply)

Home Phone Home Address Mom's Cell Dad's Cell Mom's Work Dad's Work Other _____

CHILDREN

	LAST NAME,	FIRST NAME,	MIDDLE INITIAL	BIRTHDATE	GENDER
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

FINANCIAL RESPONSIBILITY and CONTACT INFORMATION AUTHORIZATION

As a courtesy, our practice will file your claim electronically with your insurance company. You will be billed for charges not covered by your insurance company and payment is expected within thirty (30) days of receipt of our billing statement. Delinquent accounts may be placed with a collection agency. In the event that your unpaid balance is turned over to a collection agency for recovery, collection and attorney fees will be added to your balance. Returned checks will incur a \$30.00 service fee.

SIGNATURE

DATE