PATIENT INFORMATION FORM

PERSONAL INFORMATION		Date:			
Name:	First:	MI:	Last:		
Social Security #:		Birth Date:			
Address:					
City, State, Zip:					
Home Phone:		Work Phone:			
Employer:		Occupation:			
Male ☐	Female ☐	Minor ☐			
Single ☐	Married ☐	Divorced ☐	Widowed ☐	Seperated ☐	
Referred By:					

RESPONSIBLE PARTY					
Name:	First:	MI:	Last:		
Relationship to Patient:					
Birth Date:		Drivers License #:			
Social Security #:					
Address:					
City, State, Zip:					
Employer:		Occupation:			
Home Phone:		Work Phone:			
Cell Phone:		Pager #:			
Where do you prefer to receive calls?		Home ☐	Work ☐	Cell ☐	OK to leave message ☐
What is the best time to reach you?		Days:		Time:	
In case of an emergency, whom should we contact?					
Name:					
Home Phone:		Work Phone:		Cell#:	
Relationship:					

INSURANCE INFORMATION				
Name of Insured:	First:	MI:	Last:	
Insured Birth Date:		Social Security #:		
Employer:				
Occupation:			Date Employed:	
Insurance Company:				
ID #:		Group #:		
Insurance Co. Address:				
Copay:	Deductible Amount (if any):			
Additional Insurance:				
Name of Insured:			Relationship:	
Insured's Birth Date:			Soc. Sec.#:	

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health prqactitioners. I authorize and request my insurance company to pay directly to Julie Ralls, M.D.insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding balances.

Signature of patient, or parent if minor_____ Date_____