

# Patient Profile

Doctor: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City,State: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Sex: Male [ ] Female [ ]

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

## PATIENT EMPLOYMENT

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

## GUARANTOR

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City,State: \_\_\_\_\_

## PRIMARY INSURANCE

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Company: \_\_\_\_\_

## SECONDARY INSURANCE

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Company: \_\_\_\_\_

## CONTACTS

\_\_\_\_\_

\_\_\_\_\_

## EMPLOYMENT

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Primary Insured/Guarantor: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Primary Insured/Guarantor: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay all costs and expenses including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits and authorize payment of medical benefits from my insurance company and/or Medicare directly to my physician. I understand some services provided might incur costs from outside laboratories and or radiology providers.

Consent for treatment. I wish to receive examination and treatment for my medical condition. I understand that my practitioner will inform me of recommendations related to my treatment and that, unless I object, this consent includes any tests or examinations. I understand related services may involve bodily contact, touching and or direct contact of a sensitive nature.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_