Patient Forms

Responsible Party Information

SPOUSE OR RESPONSIBLE PARTY INFORMATION

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

Name: _____

☐ Male , ☐ Female ☐ Married, ☐ Single, ☐ Child, ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work _____ Ext: _____ Best time to call: _____

Address (Street/suite/city/state/zip): _____

_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____

Occupation: _____

Address (Street/suite/city/state/zip): _____

_____

INSURANCE INFORMATION

Primary

Name of Insured: _____

Last First MI

Is the insured a patient? ☐ Yes ☐ No

Insured's Birth Date _____ ID #: _____ Group #: _____

Insured's Address: _____

Last First MI

Insured's Employer Name: _____

Insured's Employer Address: _____

Last First MI

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____

Last First MI

Is the insured a patient? ☐ Yes ☐ No

Insured's Birth Date _____ ID #: _____ Group #: _____

Insured's Address: _____

Last First MI

Insured's Employer Name: _____

Insured's Employer Address: _____

Last First MI

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____