PATIENT INFORMATION

Date ____

Name ____

DOB _____________ Email_________________________

Address ____

City ____ State ___________ Zip ____________________

SSN ____ Pharmacy/City ____________________________

Home Phone # _______________________________ Cell Phone # ______________________________

Employer ____________________________________ Employer Phone # __________________________

Primary Insured Name ________________________ DOB ____________________________________

Primary Insurance____________________________ Insurance Policy # _________________________

Secondary Insurance __________________________ How did you hear about us? __________________

_______ MALE _______ FEMALE _______ OTHER _______ S ________ M ________ D ________ W

Race/Ethnicity _______________________________ Primary Doctor ___________________________

IN CASE OF EMERGENCY

Name ______________________________________ Relationship ______________________________

Address ____

City ____ State ___________ Zip ____________________

Daytime Phone # _____________________________ Cell Phone # ______________________________

- Insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or balance not paid by insurance.
- In order to control your cost of billings, we request that Cardinal Healthcare's charge for office visits be paid at the conclusion of each visit. A $35 fee will be charged to your account for any checks returned for NSF.
- I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits to which I am entitled to Cardinal Healthcare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.
- In case that I do not have insurance, my insurance company denies or only partially pays my claim, I understand that I am fully responsible for any unpaid balance.

PATIENT SIGNATURE ___________________________________ DATE _______________________

LEGAL GUARDIAN SIGNATURE ____