# Confidential Patient Information

Patient Name:_____ Date:_____/_____/_____

Gender: M F Date of Birth: _____/_____/_____ Age _____ SS #_____

Home Address:_____ Apt#: _____

City: _____ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail #1: _____ E-mail #2:_____

How were you referred to us? _____

**Employer**:_____ Occupation: _____

Employer Address: _____

City/State/Zip:_____

**Name of your Primary Doctor**: _____

Location: (street) _____ May we send your doctor information about your visit here? ☐ YES ☐ NO

**EMERGENCY** (Name and phone number of nearest relative or friend NOT living with you.)

Last Name:_____ First Name: _____ Middle: _____

Home Number:_____ Work Number: _____

Relation to Patient:_____

**X-rays and Pregnancy** X-rays can be hazardous to an unborn child.

☐ **I am pregnant.** I understand that treatment without x-rays may limit the doctor's understanding of my condition, but I consent to treatment without x-rays.

☐ I confirm that I have been advised above. At this time, to the best of my knowledge, **I am not pregnant**, and I consent to radiographic pictures (x-rays) if necessary.

## Our Policy on Insurance Benefits

This office will diligently check your insurance benefits as a courtesy to give you an idea of your "out of pocket" responsibility. We will do the work of gathering this information to help save you the "on-hold" time, and the frustration of dealing with your insurance company. **However, we are completely at the mercy of the information we are provided by your insurance company**. If your insurance company gives us the wrong information, we have no way of knowing this until billing has completely traveled through their system and is sent back to us through U.S. mail.

**It is not unusual for this process to take up to 30-45 days (sometimes more).**

While it can be a challenge, it is up to each one of us to understand our own insurance coverage. By signing below you are acknowledging that ultimately you are responsible to pay in full for services rendered to you in good faith by this office. This means that even though you pay something today, you could receive a bill later from this office for any unpaid balance.

I certify that all of the above information is true and correct. I have read and understand this office's policy regarding my insurance benefits.

_____ _____

(Patient or Guardian Signature) (Date)