Patient Information Record

Patient Information

(Please print clearly)

PATIENT'S NAME	MARITAL STATUS S M W D	DATE OF BIRTH	AGE	SOCIAL SECURITY #
PATIENT'S ADDRESS (MAILING)	CITY, STATE ZIP			HOME PHONE
PATIENT'S EMPLOYER	WORK PHONE			CELL PHONE
SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY #	DATE OF BIRTH		CELL PHONE
EMERGENCY CONTACT	RELATIONSHIP			TELEPHONE NUMBER
GUARDIAN (IF UNDER 18)	HOME PHONE			CELL PHONE

Insurance Information

INSURANCE COMPANY NAME (PRIMARY)	POLICY NUMBER
POLICYHOLDER'S NAME	POLICYHOLDER'S SOCIAL SECURITY #
INSURANCE COMPANY NAME (SECONDARY)	POLICY NUMBER
POLICYHOLDER'S NAME	POLICYHOLDER'S SOCIAL SECURITY #

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any health plan to W. Ashley Hood, DO PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signed: _____ Date:_____