



ABC RESOURCES
For Practical Healthy Living

Patient Information Form

Date: _____

PATIENT'S INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

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

Email address: _____

I'd like a courtesy appointment reminder: ☐ sent to my email address ☐ texted to my cell phone

Sex: _____ Date of Birth: _____ Age: _____ Marital Status: _____

RESPONSIBLE PARTY (statements will be sent to):

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

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

Email address: _____

Sex: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Relationship to patient: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Phone #: _____

Subscriber's Name: _____ SS#: _____

Employer: _____ Group #: _____

Date of Birth: _____ Subscriber's ID: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Phone #: _____

Subscriber's Name: _____ SS#: _____

Employer: _____ Group #: _____

Date of Birth: _____ Subscriber's ID: _____

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.

AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

SIGNED: _____ DATE: _____

(patient, or guardian if patient is a minor)