



**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)