Patient Identification Form

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

DOB: _____ **Gender:** □ M □ F **Referred By:** _____

Physical Address: _____

_____

_____

Billing Address: _____

_____

_____

Telephone Numbers:

Home: (_____) _____ - _____

Mom's Cell: (_____) _____ - _____

Mom's Work: (_____) _____ - _____

Dad's Cell: (_____) _____ - _____

Dad's Work: (_____) _____ - _____

Parent's Marital Status:

□ Single □ Separated □ Widowed

□ Married □ Divorced

Race:

□ Asian □ American Indian/AK Native □ Black/African American

□ White □ Native HI/Pacific IS □ Other

Father's Name: _____ **DOB:** _____

Employer: _____ **Job Title:** _____

Employer's Phone: (_____) _____ - _____ **Social Security Number:** _____ - ___ - _____

Mother's Name: _____ **DOB:** _____

Employer: _____ **Job Title:** _____

Employer's Phone: (_____) _____ - _____ **Social Security Number:** _____ - ___ - _____

Please list any other children in the family:

Name: _____ **DOB:** _____ **Age:** _____

Name: _____ **DOB:** _____ **Age:** _____

Name: _____ **DOB:** _____ **Age:** _____

Name: _____ **DOB:** _____ **Age:** _____

Name: _____ **DOB:** _____ **Age:** _____

Emergency Contact Information:

Name: _____ **Address:** _____

Relationship: _____ _____

Phone Number: (_____) _____ - _____ _____

My account is due and payable at time services are rendered. If hospitalized, I, the undersigned authorize that payments under the medical insurance program, otherwise payable to me, be made payable to the physician responsible for my care on any bills for services furnished to me during the effective period of this authorization. I authorize my physician to release to my insurance company, or its intermediaries or carriers, any information needed for this claim or any related to process the Medical Insurance claim. I further permit a copy of this authorization to be used in place of the original. These benefits are not to exceed the physician's regular charges for this period of care.

Signature: _____ **Date:** _____

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