

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____ Sex: F MPreferred Pronouns: She/her He/ him They/them

Siblings & Birthdays: _____

Preferred Primary Contact: Parent 1 Parent 2 Either Parent**Marital Status:** Single Married Domestic Partners Separated Divorced**Parent 1:** _____ Female Male
First Last Date of BirthPreferred Pronouns: She/her He/ him They/themAddress: _____
Street City Zip codeCell: _____ Alternate Number: _____ Occupation: _____
Occupation EmployerEmail Address _____
*Please Print Clearly***Parent 2:** _____ Female Male
First Last Date of BirthPreferred Pronouns: She/her He/ him They/themAddress: _____
Street City Zip codeCell: _____ Alternate Number: _____ Occupation: _____
Occupation EmployerEmail Address _____
Please Print Clearly

Emergency Contact: _____ Phone #: _____

Preferred Pharmacy: _____

Preferred Provider: _____

Primary Insurance: _____

PLEASE BE SURE TO INDICATE YOUR CURRENT PRIMARY INSURANCE INFORMATION. IF THIS INFORMATION IS NOT PROVIDED, YOU MAY BE HELD RESPONSIBLE FOR THE FULL COST OF SERVICES
INSURANCE INFORMATION (please provide a scanned copy of the front and back of your insurance card)

Our office will bill those insurance carriers that we are contracted with. You are responsible the deductible, share of cost, and co-payment at the time of service and any costs not a benefit of your plan. Failure to pay your copayment at the time of service will result in an administrative fee. If you do not have insurance, payment will be requested at the time of your visit.

I authorize payment of medical payments to be made directly to the provider for the services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance carrier.

APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE WILL INCUR A \$100.00 "NO SHOW" FEE

Signature: _____ DATE: _____