

Patient Information Form

Chart # _____ Date _____

Patient Name _____ Is This Your Legal Name? Yes No
First MI Last

If Not, What is Your Legal Name? _____ DOB _____ / _____ / _____
First MI Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section

Name of Responsible Party _____
First MI Last

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-Mail _____ Patient's SSN _____ Sex M F

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status Married Single Widowed Divorced Long-Term Commitment

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

I Would Like a Report to Be Sent to _____

How did you hear about us?

Mail Newspaper Ad Promotional Call Radio Insurance Yellow Pages

Sponsored Event Seminar Health/Senior Fair Website Employer

Referred by Friend _____ Referred by Physician _____

Other _____

Reason for Appointment _____

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We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous, and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

- | | | | |
|----------------------------------|---------------------------------|-------------------------------|----------------------------|
| Location and accessibility | <input type="radio"/> Excellent | <input type="radio"/> Average | <input type="radio"/> Poor |
| Adequate parking | <input type="radio"/> Excellent | <input type="radio"/> Average | <input type="radio"/> Poor |
| Convenience of appointment times | <input type="radio"/> Excellent | <input type="radio"/> Average | <input type="radio"/> Poor |
| Friendly greeting | <input type="radio"/> Excellent | <input type="radio"/> Average | <input type="radio"/> Poor |
| Clean and welcoming environment | <input type="radio"/> Excellent | <input type="radio"/> Average | <input type="radio"/> Poor |

What can we do to make your next visit more comfortable?

Insurance Information

Please give your insurance card to the receptionist.

Person Responsible for Bill _____ DOB _____ / _____ / _____
First MI Last mm dd yyyy

Address (If Different) _____ Home Phone # _____

Is This Person a Patient Here? Yes No

Occupation _____ Employer _____

Employer Address _____ Employer Phone # _____

Is This Patient Covered by Insurance? Yes No

Please Indicate Primary Insurance _____

Subscriber's Name _____ DOB _____ / _____ / _____
First MI Last mm dd yyyy

Subscriber's SSN _____ Group # _____

Policy # _____

Patient's Relationship to Subscriber Self Spouse Child Other

Patient Information Form

Insurance Information (Continued)

Name of Secondary Insurance (If Applicable) _____

Subscriber's Name _____ DOB _____ / _____ / _____
First MI Last mm dd yyyy

Subscriber's SSN _____ Group # _____

Policy # _____

Patient's Relationship to Subscriber Self Spouse Child Other

Please read carefully and sign below

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ **Initial to refuse permission to release records**

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.

Effective period for: All past, present, and future periods.

This authorization shall be in force and effect until the event of my death at which time this authorization expires.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original)

Date

Signature of Parent or Guardian

Date