

(SPECIALTY PRACTICE NAME)

Name of Patient

Encounter #

Account #

Patient Information

Last Name, First Name and Middle Name
Street Address
City,State, Zip
County

DOB:
SSN:
GENDER:
HOME PHONE:
LANGUAGE:
PRECAUTIONS/ALERTS:

Preferred Name to be Called: _____ SCHOOL ATTENDING: _____

Guardian 1

Last Name, First Name and Middle Initial
Street Address
City,State,Zip

RELATIONSHIP TO PATIENT:
DOB:
SSN:
DRIVERS LICENSE:
HOME PHONE:
CELL PHONE:
DIRECT WORK PHONE:
ALTERNATE PHONE

Guardian 2

Last Name, First Name and Middle Initial
Street Address
City,State,Zip

RELATIONSHIP TO PATIENT:
DOB:
SSN:
DRIVERS LICENSE:
HOME PHONE:
CELL PHONE:
DIRECT WORK PHONE:
ALTERNATE PHONE:

Guarantor

Last Name, First Name and Middle Initial
Street Address
City,State,Zip

RELATIONSHIP TO PATIENT:
DOB:
SSN:
DRIVERS LICENSE:
HOME PHONE:
CELL PHONE:
DIRECT WORK PHONE:

Health Plan/Insurance Company Verification Policy Holder Employer

<u>1. Name of Insurance Company</u>	<u>Status:</u>	<u>Name:</u>
<u>Street Address or PO Box</u>	<u>Date:</u>	<u>Relationship:</u>
<u>City,State, Zip</u>		<u>Group #:</u>
		<u>Policy ID #:</u>

<u>2. Name of Secondary Insurance</u>	<u>Status:</u>	<u>Name:</u>
<u>Street Address or PO Box</u>	<u>Date:</u>	<u>Relationship:</u>
<u>City,State,Zip</u>		<u>Group #:</u>
		<u>Policy ID #:</u>

COMMENTS: