# CENTER for TEAM HEALTHCARE

## PATIENT INFORMATION

(please answer all questions completely)

| Last Name | First Name | Date of Birth | Sex | Marital Status | |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address | City | State | Zip | Home Phone |
|---|---|---|---|---|
| | | | | |

| Physical Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Name & Address of Employer | Occupation | Work Phone |
|---|---|---|
| | | |

| Email Address | Cell Phone |
|---|---|
| | |

| Name of Spouse (in case of child list the Other Parent) | Spouse Cell Phone | Spouse Work Phone |
|---|---|---|
| | | |

How did you hear about our clinic? ❑ Phone Book ❑ Insurance Co. ❑ Advertising ❑ Our Website

❑ Another Patient (name) _____ ❑ Physician Referral (name) _____ ❑ Other _____

## RESPONSIBLE PARTY INFORMATION (if not patient)

| Last Name | First Name | Date of Birth | Sex | Marital Status | |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address | City | State | Zip | Home Phone |
|---|---|---|---|---|
| | | | | |

## INSURANCE INFORMATION (if no insurance write CASH)

| Primary Insurance Company | Address | City | State | Zip | Phone Number |
|---|---|---|---|---|---|
| | | | | | |

| Name of Insured | Date of Birth | | Relationship to Patient |
|---|---|---|---|
| | | | |

| Employer Name | Group No. | Policy No. | Employer Phone |
|---|---|---|---|
| | | | |

| Secondary Insurance Company | Address | City | State | Zip | Phone Number |
|---|---|---|---|---|---|
| | | | | | |

| Name of Insured | Date of Birth | Social Security No. | Relationship to Patient |
|---|---|---|---|
| | | | |

| Employer Name | Group No. | Policy No. | Employer Phone |
|---|---|---|---|
| | | | |

I agree that the information listed above is accurate and legitimate to the best of my ability. I, the undersigned, give permission to release any information to third party carriers should it be requested to process my medical claims in this office. I also recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree, that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions. A finance charge of 1.5% per month (annul rate of 18%) will be charged on all balances over 90 days regardless of pending insurance claims, unless other arrangements have been made with the provider. A $25.00 charge will be added to your account for each returned personal check.

_____ _____

DATE PATIENT SIGNATURE