



## PATIENT INFORMATION FORM

**Please Print and Complete All Entries**

PATIENT NAME (Last – First – Middle Initial)		DATE OF BIRTH	AGE	MARITAL STATUS S( ) M( ) D( ) W( )
Mr. Ms. Mrs.				
STREET ADDRESS			HOME PHONE ( )	
CITY – STATE – ZIP			CELL PHONE ( )	
E-MAIL ADDRESS			WORK PHONE ( )	
PATIENT'S EMPLOYER		EMPLOYER ADDRESS		
SOCIAL SECURITY NO. (SSN)	OCCUPATION	[ ] FULL-TIME [ ] PART-TIME [ ] STUDENT		DRIVERS LICENSE NO.
NAME OF SPOUSE	SPOUSE DATE OF BIRTH	AGE	SPOUSE SSN	
SPOUSE EMPLOYER	SPOUSE EMPLOYER ADDRESS			SPOUSE WORK PHONE NO.
NEAREST RELATIVE NOT LIVING WITH YOU	Address	RELATIONSHIP	RELATIVE'S PHONE NO. ( )	
IN CASE OF EMERGENCY, NOTIFY:			EMERGENCY CONTACT PHONE NO. ( )	
REFERRED TO THIS OFFICE BY:	Address	PHONE NO.		
WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?			<b>I WILL BE PAYING TODAY BY:</b> <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card <input type="checkbox"/> Payment Plan	

## INSURANCE INFORMATION

PRIMARY INSURANCE NAME		Address	PHONE NUMBER ( )
NAME OF INSURED	RELATIONSHIP TO INSURED	I.D. No.	GROUP OR POLICY NO.
SECONDARY INSURANCE NAME		Address	PHONE NUMBER ( )
NAME OF INSURED	RELATIONSHIP TO INSURED	I.D. No.	GROUP OR POLICY NO.

I certify by my signature below that I understand and agree that I am ultimately responsible for payment. I further certify that this information is true and correct to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize ALISTER A. GEORGE, MD to release any medical information needed by my insurance company. I furthermore authorize payment directly to ALISTER A. GEORGE, MD for any insurance payments or benefits otherwise payable to me. THIS IS TO INCLUDE ANY MAJOR MEDICAL BENEFITS IN ADDITION TO BASIC BENEFITS PAYABLE. A copy of this authorization shall be as valid as the original. I understand that I am liable for any fee not paid by insurance benefits.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_