PATIENT INFORMATION SHEET

NAME _____ **DATE** _____

ADDRESS _____
STREET **CITY** **ZIP CODE**

PHONE NUMBER _____ **DATE OF BIRTH** _____

SOCIAL SECURITY NUMBER _____ **MARITAL STATUS** _____

PATIENT'S EMPLOYER _____ **OCCUPATION** _____

EMPYOYER'S ADDRESS _____ **PHONE** _____

RESPONSIBLE PARTY _____ **RELATIONSHIP** _____

SOCIAL SECURITY NUMBER _____ **DATE OF BIRTH** _____

ADDRESS _____ **PHONE**_____

REFERRED BY_____

*****PRIMARY INSURANCE**_____

POLICY HOLDER_____ **DATE OF BIRTH**_____

IDENIFICATION NUMBER_____ **GROUP/POLICY #**_____

*****SECONDARY INSURANCE**_____

POLICY HOLDER_____ **DATE OF BIRTH**_____

IDENIFICATION NUMBER_____ **GROUP/POLICY #**_____

IN CASE OF EMERGENCY, CONTACT _____
(NAME, PHONE NUMBER, RELATIONSHIP)

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I, HEREBY, AUTHORIZE ENDOCRINE CONSULTANTS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.
I, HEREBY ASSIGN THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

PATIENT'S ARE RESPONSIBLE FOR CO-PAYMENTS, DEDUCTABLES AND ANY OTHER NON-COVERED SERVICES AT THE TIME OF VISIT.

_____ _____
SIGNATURE **RELATIONSHIP**