TODAY'S DATE _____ **PATIENT INFORMATION** CHART #_____

PATIENT NAME _____ SEX (M/F) _____
LAST FIRST MIDDLE
BIRTHDATE _____
MAILING ADDRESS_____ AGE _____

CITY, STATE _____ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐

ZIP CODE _____ PHONE _____

EMAIL: _____ REFERRING DOCTOR _____ RELATIONSHIP TO PERSON FINANCIALLY RESPONSIBLE

SS #_____ _____

PERSON FINANCIALLY RESPONSIBLE

NAME_____

ADDRESS_____

CITY, STATE _____

ZIP CODE_____ PHONE _____

SS #_____

DATE OF BIRTH_____

EMPLOYER NAME _____

ADDRESS _____

PHONE _____ EXT _____

SPOUSE OF PERSON FINANCIALLY RESPONSIBLE

NAME _____

SS # _____

DATE OF BIRTH _____

SPOUSE'S EMPLOYER

NAME _____

ADDRESS _____

PHONE _____

INSURANCE INFORMATION

IF ACCIDENT, GIVE DATE _____ WERE YOU INJURED ON THE JOB? _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

PREFERRED PHARMACY _____

I HEREBY AUTHORIZE DR.(S) BOTROS AND POLLOCK TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT.

(SIGNATURE) PATIENT OR PATIENT/GUARDIAN _____

I AUTHORIZE ALL PROVIDERS, HOSPITALS, MEDICAL CARE FACILITIES, AND PHARMACIES TO RELEASE TO BOTROS & POLLOCK, PA ALL INFORMATION REGARDING MY PAST AND CURRENT MEDICATIONS.

(SIGNATURE) PATIENT OR PATIENT/GUARDIAN_____