

**PATIENT SIGN -IN SHEET**

Date \_\_\_\_\_ Referred By \_\_\_\_\_

Patient's Name (first, middle, last) \_\_\_\_\_

Permanent address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone home ( ) - - Cell ( ) - -

Patient's e-mail address \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Primary Ins Subscriber's Name & Date of Birth \_\_\_\_\_

Secondary Ins Subscriber's Name & Date of Birth \_\_\_\_\_

Drivers License No. \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Marital Status (circle one): Single, Married, Widowed, Divorced, Separated

Spouse's Name : \_\_\_\_\_ Employed by \_\_\_\_\_

Work Phone \_\_\_\_\_

If someone other than the patient is responsible for payment, please list their name and address:

(This does not pertain to insurance payments)

\_\_\_\_\_  
\_\_\_\_\_

Medicine Allergies: \_\_\_\_\_

MEDICAL INSURANCE: F For copying purposes, please give your insurance I.D. Card to the secretary

Patients or Authorized Person's Signature. I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below.  
Signed \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment of medical benefits to undersigned physician for service described below  
Signed (insured or authorized person) \_\_\_\_\_ Date \_\_\_\_\_

**ANY AMOUNT NOT COVERED BY YOUR INSURANCE SHOULD BE PAID AT THE TIME SERVICES ARE PROVIDED.**

\$10.00 CHARGE FOR ALL RETURNED CHECKS  
PAYMENT IS EXPECTED AT EACH APPOINTMENT

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED BY ME.**

Patients signature \_\_\_\_\_ Date \_\_\_\_\_