PATIENT INFORMATION

Name:_____ Birthdate: _____ Age: _____ Sex: _____

Mailing Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Business Phone: _____

Occupation: _____ Employer: _____

Social Security Number:_____Marital Status: _____ Spouse's Name:_____

Allergies: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name: _____ Relationship to Patient: _____

Address: _____

Social Security Number _____ Birthdate: _____ Phone: _____

Occupation: _____ Employer: _____

Employers's Address: _____ City:_____ State: _____ Zip: _____

INSURANCE INFORMATION:

Insurance Company: _____ ID #:___ _____

2nd Insurance Company: _____ID #:___ _____

NEAREST RELATIVE AND EMERGENCY CONTACT:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

I understand and agree that:

1. Professional Fees are due and payable at the time such services are rendered.
2. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to hospital clinic benefits for any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to patient, said benefits are hereby assigned and directed to hospital clinic.
3. FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital clinic in full at discharge. Should account become delinquent and subject to collection action, the undersigned shall pay reasonable attorney's fees, court costs, and collection expense up to 50% of the principle owing. All accounts bear interest of 1.5% per month, 18% per annum.
4. Medical information may be furnished to my insurance carrier at their request.

SIGNATURE: _____ Date: _____