Patient Information

Date:________________________________

First Name:__________________ Middle Initial:_____ Last Name:__________________________

Address:____

City:_________________________State:_____________ Zip Code:___________________

Home Phone:_________________ Cell Phone:____________________

Work Phone:__________________ Extension:___________

Sex: ____ Male ____ Female

Birth Date:__________________ Age:_______ Soc. Security #:______________________________

Martial Status:____Married ____Single ____Divorced ____ Seperated ____ Widowed

E-Mail:____

I would like to receive correspondences via e-mail ____Yes ____ No

Employer:____

Employer Address:____

City:____________________________State:_______ Zip Code:_______________

Primary Insurance Information

Subscriber's Name:______________________________ Relationship to Patient:______________

Subscriber's SSN:___________________________ Subscriber's DOB:________________________

Insurance Company:___________________________ Member Id #:_________________________

Insurance Company Address:____

City:__________________ State:________ Zip Code:__________

Employer:____

Secondary Insurance Information

Subscriber's Name:______________________________ Relationship to Patient:______________

Subscriber's SSN:___________________________ Subscriber's DOB:________________________

Insurance Company:___________________________ Member Id #:_________________________

Insurance Company Address:____

City:__________________ State:________ Zip Code:__________

Employer:____

Please be advised : Payment is expected at the time of service. We do not accept secondary insurance, nor do we bill co-pays, deductibles or "non-covered services." We will do our best to verify your coverage prior to your appointment. However, if you fail to bring appropriate information to your appointment, we will ask you to pay in full and give you a receipt to submit to your insurance company. Any and all debt incurred by the patient is the responsibility of the patient at the time of service, regardless of insurance coverage at that time. All unpaid delinquent debt will be prosecute in Rapides Parish and patient will pay the fees associated with collecting their debt

By signing this I understand and agree with the above statements.

Patient/Responsible Party:_____________________________________ Date:_________________________