Hello! Welcome to our office!

Please print the following information

This information is important for our records and your health.

Date: _____

Patient Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Work Phone: _____ Employed By: _____

Work Address: _____ City: _____

State: _____ Zip: _____ Marital State: S M D W

TDL#: _____

Social Security No: _____ Family Physician: _____

Referred to our office by: _____

Insured's Name: _____ Relationship: _____

Insured's Employer: _____ Insured's Work #: _____

Insured's SS #: _____ Insured's Birthday: _____

Primary Insurance: _____ Address: _____

Phone #: _____ ID#: _____

Secondary Insurance: _____ Address: _____

Phone #: _____ ID#: _____

Emergency Contacts:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____

Signature

Nature of problem _____
Have you been treated for any of the following:
_____Diabetes _____Liver Disease _____Anemia
_____Epilepsy

_____High Blood Pressure _____Kidney Disease _____Blood Clots or Phlebitis

_____Heart Disease _____ Herpes Infection _____ Thyroid Disease

_____ Asthma _____ Sexually Transmitted Disease _____ Abnormal Pap

_____ Menstrual Problems _____ Endometriosis _____ Seizures

Have you had any surgery in the past: _____

Any significant family history of disease : _____

Pregnancies : How many ? _____

Born Alive _____ Cesareans: _____ Indication: _____

Premature Births less than 5 ½ lbs. _____ Miscarriages: _____

Abortions: _____ Birth Defects: _____

What medication do you take now including birth control:_____

Last pap smear was:_____ Was it abnormal ? _____

Any questions or problems about sex that you would like to discuss ?
_____

Have you had any problems with any type of birth control ?
_____

Have you had any difficulty becoming pregnant ?
_____

If you smoke, how many cigarettes a day ? _____ How long ? _____

POLICY FOR INSURANCE PPO'S AND HMO'S

If you are covered under an HMO or PPO insurance with your company, it is YOUR RESPONSIBILITY to notify the receptionist that you are on a certain plan and give your card and/or referral BEFORE SERVICES ARE RENDERED. Should you NOT have your insurance card and/or referral with you at the time of service, you will be asked to either pay in full for services rendered or re-schedule your appointment for a time when you can bring the insurance card and/or referral.

DEDUCTIBLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF THE VISIT, AND WE WILL BILL YOUR INSURANCE FOR THE BALANCE UNDER THESE PLAN PROVISIONS. AFTER YOUR INSURANCE PAYS AND THE INSURANCE COMPANY SAYS THAT YOU STILL HAVE A BLANCE, YOU WILL BE RESPONSIBLE FOR THE BALANCE WHICH IS DUE WITHIN 30 DAYS AFTER YOUR RECEIVE YOUR FIRST STATEMENT.

Some services rendered in this office are considered office surgery by your insurance company. This may result ion a higher co-payment or charges may be subject to a surgical deducible. As a result, you may be responsible for a higher co-payment, payment of surgical deductible and/or full payment of services rendered at the time of your visit. If you understand and agree with this policy, please sign below.

Thank you,

Dr. Michael Hunter

_____ _____

Patient's Signature Date

Acknowledgement of Receipt

Of

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent of Authorized Representative (if applicable)

_____

Signature