



PATIENT INFORMATION RECORD
(Please Print or Write Legibly)

REFERRED BY _____ **FAMILY PHYSICIAN** _____

Patient's Name (First, Middle, Last)		Date of Birth	Age	Marital Status			Sex			
				S	M	W	D	Sep	M	F
Patient's Street Address			City and State			Zip Code	Home Phone			
Social Security No.	Employer	Occupation			E-mail Address					
Employer's Street Address		City, State, Zip Code			Business Phone					
Spouse's or Parent's Name										
Spouse's or Parent's Security #		Spouse's or Parent's Employer		Employer's Address			Phone			
Person to contact in case of emergency: Name & Street Address			City & State		Phone No.		Relationship			

INSURANCE INFORMATION	
INSURANCE COMPANY #1	
Name of Company _____	Address _____
Policy Number _____	Group Number _____ Policyholder _____ DOB _____
INSURANCE COMPANY #2	
Name of Company _____	Address _____
Policy Number _____	Group Number _____ Policyholder _____ DOB _____
MEDICARE # _____	MEDICAID # _____
Name on card _____	Name on Card _____

PAYMENT IS REQUESTED AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED. I AUTHORIZE RELEASE OF THIS INFORMATION TO MY INSURANCE COMPANY IF NECESSARY FOR REIMBURSEMENT, AND PAYMENT TO DR. FURNER IF NOT ALREADY PAID.

DATE

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

I AUTHORIZE ANY PHYSICIAN, HOSPITAL, LABORATORY OR X-RAY FACILITY TO RELEASE TO BONNIE FURNER, M.D., ANY AND ALL MEDICAL INFORMATION, HOSPITAL RECORDS, LABORATORY STUDIES OR X-RAYS THAT MAY BE REQUESTED. A COPY OF THIS AUTHORIZATION IS AS BINDING AS THE ORIGINAL.

DATE

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

Account # _____