Patient Information

Name:_____ _____ _____
Last Name First Name Middle

Social Security #_____ Birthdate:_____
Marital Status_____ Race:_____ Gender: M or F

Address:_____

Zip code:_____ City:_____ State:_____

Home Phone:_____ Cell phone:_____ Work Phone:_____

Emergency Contact: Name_____ Phone#:_____

What pharmacy do you prefer to use?_____ Location:_____

Insurance Information:
Policy Holders Name:_____ Birthdate:_____ Social Security#_____

Primary Insurance:_____ Policy#_____

Secondary Insurance:_____ Policy#_____

Is the above patient a minor: Y or N If yes please provide the following information:
Mother: Name_____ Birthdate:_____
Address:_____

Father: Name_____ Birthdate:_____
Address:_____

Patient's read and sign agreement:

1. I hereby give my consent for Dr. Jana Peters' office to evaluate and treat the above patient.
2. I have been provided the Privacy Practices Notice for Dr. Jana Peters' office.
3. I have also been provided and agree with the Financial Policy of Dr. Jana Peters' office.
4. I understand that my personal health information will be used for the purpose of treatment, payment, and the coordination of health care needs of the patient.
5. I understand the practice reserves the right to review pharmacy profiles.
6. We reserve the right to do a random drug screen at any time.
7. I , the undersigned certify that I (or my dependent) have insurance coverage with the above insurance companies and assign directly to Dr. Jana Peters all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date