

**Patient's Name** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Prefers to be called

Address \_\_\_\_\_  
Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Work \_\_\_\_\_ Preferred contact:  Home  Cell  Work  E-mail

Any restrictions for contacting you?  No  Yes If so, what restrictions \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Patient's Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_  
Street & Suite # City State Zip

**Emergency Contact** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Primary doctor** \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**How did you hear about Dr. Peters?**  ASPS: \_\_\_\_\_  Magazine: \_\_\_\_\_

Care Credit: \_\_\_\_\_  Website: \_\_\_\_\_  Seminar: \_\_\_\_\_

Newspaper: \_\_\_\_\_  Insurance: \_\_\_\_\_  Hospital: \_\_\_\_\_

Friend/Relative: \_\_\_\_\_  Doctor: \_\_\_\_\_  Other: \_\_\_\_\_

If you were referred by a specific person, may we thank them?  Yes  No Name: \_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Co:** \_\_\_\_\_ Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

**Secondary:** \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_

I understand and agree that (regardless of my insurance policy), I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I also understand that if payments are not made on time, there will be service charges and interest will be added. I have read all the information contained in the financial policy. I certify that, to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my health or any above information.

I hereby authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to the above physician of the surgical and/or medical benefits for her services.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_