PATIENT INFORMATION

Date: _____

Purpose of visit today: _____

Date Last Menstrual Period Started _____

Name_____ Date of Birth_____Age:_____
Address_____ Apt#_____Marital Status_____
City_____ST_____ Zip Code_____
SS#_____Home#( ) _____Work#( )_____EXT_____
Cell Phone # ( ) _____Employer_____

Primary Insurance_____Group#_____ Policy#_____
Name of Insured_____ Relationship to Insured _____D.O. B. _____
SS# _____ Address if different _____
Employer_____ Employer Phone_____

Secondary Insurance_____ Group #_____ Policy #_____
Name of Insured_____ Relationship to Insured_____ D.O.B._____
SS#_____ Address if different_____
Employer_____ Employer Phone_____

EMERGENCY INFORMATION:
Name_____Relationship to patient_____
Address_____
Home# ( )_____ Work# ( )_____ EXT_____

FINANCIAL POLICY : ***PLEASE READ CAREFULLY AND SIGN:***

I understand that I am responsible for all charges incurred for services rendered by Dr. Juaquita Callaway, and that payment is expected in full on the day of service unless prior arrangements have been made. If my visit is covered by my insurance plan, I agree to pay my co-pay/co-insurance**. I further agree that if my account is not paid in a satisfactory manner, I am responsible for the amount of my bill plus all reasonable charges incurred in the collection of my account. This includes any charges billed to my insurance company which are not paid within 90 days (Please speak with the receptionist prior to your visit if you are unprepared to pay your fee today.)**

Patient Signature:_____ Date:_____
Responsible Party if patient is a minor_____

ASSIGNMENT OF BENEFITS:
I authorize the release of any medical information necessary to process my insurance claims.
I authorize and request payment of medical benefits directly to my physician.
I hold Dr. Callaway and staff blamelss for the unlawful use of this information by other entities in the processing of my claim.
SIGNATURE:_____
DATE:_____

RELEASE OF INFORMATION:
I hereby authorize the above physician to furnish information to my referring physician or to any physician whom I may be referred for additional treatment. I understand that the above information will remain private and used only for the intended purpose.

SIGNATURE_____
DATE:_____