PATIENT INFORMATION

PATIENT'S NAME:_____ Age_____ Birthdate_____
Last First Middle

Please circle one: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow Sex _____

Address:_____
Street City, State, Zip Code

Home Phone:_____ Business Phone:_____

Employer:_____ Address:_____

Occupation:_____ City, State, Zip:_____

Social Security No.:_____ Driver License No.:_____

Name of nearest relative (not living with you):_____ Phone:_____

IF PATIENT IS UNDER 18 YEARS OF AGE OR RESIDING WITH PARENT, PLEASE COMPLETE:

Father's Name:_____ Mother's Name:_____

Father's Employer:_____ Mother's Employer:_____

Employer's Address:_____ Employer's Address:_____

Business Phone:_____ Business Phone:_____

Name of Responsible Party:_____

Was this an accident: ☐ Yes ☐ No on the job: Yes ☐ No ☐ Date of accident:_____

Have you had any surgery within the last 90 days? Yes ☐ No ☐ Yes? Date:_____

How do you plan to pay for today's visit? Cash____ Check____ Visa____ MC____ AMEX____ Discover___

Primary Insurance

Insurance Company:_____

Insurance Policy No.:_____

Insurance Group No.:_____

Insured Name:_____

Relationship to Insured:_____

Insured Employer:_____

Insured Social Security No.:_____

Insured Date of Birth:_____

Insured Address (if different from patient)

_____

_____

Is patient covered by additional insurance? Yes No

Insurance Company:_____

Insurance Policy No.:_____

Insurance Group No.:_____

Insured Name:_____

Relationship to Insured:_____

Insured Employer:_____

Insured Social Security No.:_____

Insured Date of Birth:_____

Insured Address (if different from patient)

_____

_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Cheryl P. Lopez, D.O., P.A.** 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 hereby authorize to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission.

Responsible Party Signature_____ Relationship_____ Date_____