



Welcome

PATIENT INFORMATION

Patient chart #: _____ Date: _____

Last name: _____ First name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: () _____

Birth Date: ___/___/___ Male Female

Person to contact in emergency: _____

Phone #: () _____ Relationship: _____

Ethnicity: White Hispanic Black Asian Refuse to report

Responsible Party

Name of person responsible for this account: _____

Phone #: () _____

Pharmacy Name: _____

Insurance information

Insurance _____

Insurance _____

Insurance _____

Insurance _____

Sliding fee scale: Date _____ Date _____ Date _____

Authorization, Release & Contractual Agreement

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize evolution and treatment as deemed necessary by the Medical and Dental personnel including blood being drawn, specimen collection pharmaceutical administration, and immunizations I authorize the physician to release any information including the diagnose and the records of any treatment or examination rendered to me or my child during the period of such medical or dental care to third party payors and/or health partitoners. I understand that my insurance carrier may not cover all procedures. I agree to be responsible for payment of all services rendered on my behalf or my dependence.

I HAVE RECEIVED THE PATIENT BILL OF RIGHTS.

X _____

Signature of patient or parent if minor

Date

X _____

Signature of Witness

Date