

# Patient Information Form

**PLEASE PRINT AND COMPLETE ALL ENTRIES**

Patient Name (Last, First, MI)		Date of Birth ____/____/____	Age	Marital Status	TODAY'S DATE ____/____/____
Address	City	State	Zip	Social Security Number	
Email address		Cell Phone (____) _____-_____		Home Phone (____) _____-_____	
Employer Name: Address:		Occupation		Work Phone (____) _____-_____	
Spouse's Name (Last, First, MI)	Date of Birth ____/____/____	Social Security Number		Phone (____) _____-_____	
Emergency Contact (Last, First, MI)	Relationship to Patient			Phone (____) _____-_____	

## INSURANCE AND PAYMENT INFORMATION

Person Responsible for Payment	Address (Street – City – State – Zip)	Phone (____) _____-_____
Primary Insurance Carrier	Secondary Insurance Carrier	Supplemental Insurance Carrier

## PRIMARY CARE AND REFERRING PHYSICIAN INFORMATION

Referring Physician	Address (Street – City – State – Zip)	Phone (____) _____-_____
Primary Care Physician	Address (Street – City – State – Zip)	Phone (____) _____-_____
Specialty Physician	Address (Street – City – State – Zip)	Phone (____) _____-_____

## PLEASE SIGN EACH LINE

**Person Responsible for payment:** I understand that I am financially responsible for any charges not covered by insurance; that I will be charged at a rate of 1.0% per month (12% APR) on balances over 30 days and that I am liable for all legal and collection fees. All overdue accounts will be sent to collections 90 days from the date of service.

X \_\_\_\_\_  
**Signature of person financially responsible for payment** \_\_\_\_\_  
**Date**

**Release of Medical Information:** I give consent to the release of medical information to my Physician related to treatments at The Rejuvenation Center. I hereby assign medical benefit payments directly to The Rejuvenation Center for professional services rendered. I also authorize the release of patient information, as may be necessary, to the proper authorities to determine benefits. A photo-copy or facsimile hereof shall be as valid as the original.

X \_\_\_\_\_  
**Signature of Patient (IF patient is a minor, guardian may sign)** \_\_\_\_\_  
**Date**

I acknowledge that I have received the **Notice of Privacy Practices Packet**.

X \_\_\_\_\_  
**Signature of Patient (IF patient is a minor, guardian may sign)** \_\_\_\_\_  
**Date**