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PATIENT INFORMATION

Date _____ Patient Name _____ SSN _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell # _____
Birthdate _____ Age _____ Minor Single Divorced Separated
Patient's or parent's employer _____ Male Female
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relation to Patient _____
Address _____ Home Phone _____ Work Phone _____

INSURANCE INFORMATION

Name of policy holder _____ Relation to patient _____
Birthdate _____ SSN _____ Address _____
Home phone _____ Name of Employer _____
Work phone _____ Insurance Company _____
Group # _____ Union or Local # _____
How much is your deductible? _____ Have you met your deductible? _____ Co/pay Amt _____
Do you have additional insurance? yes no if yes complete the following:
Name of insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Address _____
Home phone _____ Name of Employer _____
Work phone _____ Insurance Company _____
Group # _____ Union or Local # _____

**HIPPA PRIVACY RULE
CONSENT, INFORMATION DISCLOSURE, AND INSURANCE AUTHORIZATION**

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPPA) and will be used as follows only with patient consent. I hereby authorize Dimond Medical Clinic to furnish information to other providers, health care treatment facilities, and my insurance companies for purposes of treatment, payment, and health care operations. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature Date Witness Date