

**Patient History Information (Please Print)**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. \_\_\_\_\_ Sex:  Male  Female

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Referred by:  website  friend  television  physician (his/her name) \_\_\_\_\_

Marital status: Married \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

If child, name of  mother  father: \_\_\_\_\_ Telephone: \_\_\_\_\_

Or legal guardian's name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name, address and relationship of Responsible Party:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Person we should contact in case of emergency (next of kin not living with you):

Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Employment

Patient's employer: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Spouse or parent employer: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Information (Please provide all requested information)

Primary insurance company: \_\_\_\_\_ Secondary insurance company: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Subscriber name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

ID Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Effective date: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective date: \_\_\_\_\_

Authorization to pay insurance benefits & release information to insurance company

I hereby authorize my doctor and/or such assistants as may be selected by him/her to perform such procedures as are necessary and desirable, including but not limited to the services of pathologist or a laboratory. The authorization granted in this paragraph shall extend to remedying conditions that are not known to my doctor at the time the procedure commences.

I hereby authorize payment directly to Drs. Parsley, Hodge, Sonnier, Ahrens & Waldman. I understand I am financially responsible to the above physicians for charges not covered by this authorization. I authorize Drs. Parsley, Hodge, Sonnier, Ahrens & Waldman to release information required to complete my insurance claim, and if necessary I authorize my doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_