

# Welcome to our Office

Your referring doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Your Doctor's last name

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Home Address \_\_\_\_\_ Apt. \_\_\_\_\_

City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age(in Years) \_\_\_\_\_ Male/Female \_\_\_\_\_

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

Social Security # \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired: Yes \_\_\_\_\_ No \_\_\_\_\_

Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

(Street)

(City)

(Zip)

**A) The Policy Holder: If same person as above, do not complete this section.**

Your Relation to the Patient — Are you the spouse, the parent or other relationship?

Name of policy holder \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

**B) Financial Statement:** I authorize my insurance company to pay benefits directly to Dr. Mowbray. I understand that I am financially responsible for the charges not covered by my insurance plan. In the event of default, I promise to pay collection costs and applicable fees as may be required to obtain collection of this account and I will be reported to the Credit Bureau. I understand that I am financially responsible for paying for services rendered in the event that insurance makes payment to me. I understand that if I do not give 24-hour notice for a canceled appointment, I will be assessed a \$30.00 charge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Your relationship to the patient

Date

(Write “self” if you are the

patient)

**C) Important:**

Who should we contact in an  
emergency\_\_\_\_\_

What is their phone number\_\_\_\_\_

*Thank you for completing this information. It will be placed in your personal chart.*