

# Patient Information Form

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Patient Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Beeper/Cellular: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security: \_\_\_\_\_

## **Employment Information:**

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Work phone No: \_\_\_\_\_ Ext. \_\_\_\_\_

## **In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

In our Continuing effort to respect our privacy and maintain the confidentiality of your care, please indicate in the space below how you want to be contacted. (Phone / home / cell / work / e-mail please explain).

\_\_\_\_\_

## **Financial Policy:**

Thank you for selecting Dr. Benton Baker III for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

\_\_\_\_\_  
Patient's Signature or Person with Authority to Consent for Patient

\_\_\_\_\_  
Date