BARBER & RICHARDSON, PC.
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PATIENT INFORMATION SHEET

PHYSICIAN YOU ARE SEEING TODAY____

DATE OF OFFICE VISIT_______________ REFERRING PHYSICIAN___________________________

_________________________________ _______________________________ _________
LAST NAME FIRST NAME MI

______________________________ __________________ ____________________________
PATIENT'S SOCIAL SECURITY # DATE OF BIRTH EMAIL ADDRESS

____
STREET ADDRESS

____
CITY, STATE, ZIP

_________________________ __________________________ _____________________
HOME PHONE BUSINESS PHONE MOBILE/CELL

MARITAL STATUS S___ M____W_____ SPOUSE NAME_____________________________

_____________________________ ____
PATIENT'S EMPLOYER EMPLOYER ADDRESS

_____________________________ ____
INSURANCE COMPANY INSURANCE ID#

We scan all insurance cards so the insurance ID is not required

_____________________________ _______________________ _____________________
EMERGENCY CONTACT RELATIONSHIP PHONE NUMBER

____ ____________________________
RESPONSIBLE PARTY IF OTHER THAN PATIENT RELATIONSHIP

____________________________ ________________________ _____________________
HOME PHONE BUSINESS PHONE MOBILE/CELL

___________________________________ ____
RESPONSIBLE PARTY EMPLOYER EMPLOYER ADDRESS

I hereby authorize Barber & Richardson, PC. to bill my insurance carrier for any services rendered by him or any agents of his practice. With this authorization I assign any and all benefits payable for services rendered by Barber Surgical Services, PC. or agents of his practice to Barber & Richardson, PC. I understand that I am responsible for any amount not covered by my insurance plan.

I hereby authorize the release of any and all medical information necessary to the treatment I receive while under the care of Barber & Richardson, PC. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports to Barber & Richardson, PC. A copy of this authorization shall be valid as the original.

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PATIENT OR GUARDIAN SIGNATURE DATE