

DATE \_\_\_\_\_

**PATIENT INFORMATION**

LAST NAME		FIRST NAME			MI
SOCIAL SECURITY NUMBER	SEX ø FEMALE ø MALE	DATE OF BIRTH MONTH / DAY / YEAR		MARITAL STATUS ø SINGLE ø MARRIED ø DIVORCED ø WIDOWED ø SEPARATED	
ADDRESS		CITY	STATE	ZIP CODE	
HOME TELEPHONE ( )	WORK TELEPHONE ( )		CELL PHONE ( )		
EMPLOYER	ADDRESS				
CITY	STATE	ZIP CODE	EMPLOYER'S TELEPHONE ( )		
OCCUPATION	ø PART TIME ø FULL TIME	REFERRING PHYSICIAN		TELEPHONE	

**RESPONSIBLE PARTY INFORMATION**

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)			RELATIONSHIP TO PATIENT	
ADDRESS		CITY	STATE	ZIP CODE
HOME TELEPHONE ( )	WORK TELEPHONE ( )		EXTENSION	
GUARANTOR'S EMPLOYER	ADDRESS			
CITY	STATE	ZIP CODE	EMPLOYER'S TELEPHONE ( )	

**EMERGENCY CONTACT INFORMATION**

EMERGENCY CONTACT NAME		ADDRESS		
CITY	STATE	ZIP CODE	HOME TELEPHONE ( )	
WORK TELEPHONE ( )	EXTENSION	RELATIONSHIP		

**INSURANCE INFORMATION**

PRIMARY INSURED PARTY (First and Last Name)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	INSURED'S EMPLOYER	
PRIMARY INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	
INSURANCE CO. ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

**SUPPLEMENTAL INSURANCE INFORMATION**

SUPPLEMENTAL INSURED PARTY (First and Last Name)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	INSURED'S EMPLOYER	
SUPPLEMENTAL INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	
INSURANCE CO. ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

**FINANCIAL RESPONSIBILITY:** I understand payment is due in full at the time of service, unless special payment arrangements have been made with Business Services. If my insurance is a PPO/HMO with which Dr. John contracts, I am responsible for my copays, deductibles, and non-covered services. I understand that if my insurance carrier is one with which Paul W. John, M.D., P.A. has a contract, that contract includes a provision for benefits to be paid directly to Dr. Paul W. John.

SIGNED (INSURED PERSON) \_\_\_\_\_ DATE \_\_\_\_\_ WITNESS \_\_\_\_\_

**CONSENT FOR TREATMENT:** I do hereby consent to necessary examination procedures and/or treatments prescribed by Dr. Paul W. John, MD, his assistants, or designees as is necessary in his/her judgment.

SIGNED (INSURED PERSON) \_\_\_\_\_ DATE \_\_\_\_\_ WITNESS \_\_\_\_\_