Today's Date_____

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Complete all questions. This information is necessary to better serve your needs. If you need help, please ask the receptionist.

Name_____ Home Phone_____ Cell _____

Address_____City_____State_____Zip_____

E-mail Address _____ Age_____ Birth Date_____

Marital Status: S M W D P Number of Children_____

Please circle one payment type: Cash Check MC/Visa How did you hear about us?_____

If referred, by whom?_____

Describe the Major Complaints that you bring to our office: _____

_____

Is your condition due to an accident? Yes_____ No_____ Date of Accident_____

Name of Attorney_____

Type of Accident? Auto_____ Work/On Job_____ At Home_____ Other_____

Your Medical Doctor_____ Dr.'s Phone #_____

Your Employer_____Occupation_____Yrs. On Job_____

Employer Address_____City_____State_____Zip_____

Office Phone_____ Your SS#_____ Driver's License #_____

Do you have health insurance where you work? Yes_____ No_____ Plan/Group#_____

Name of your Insurance Company_____

Name of Spouse or Parent_____---_____Birth Date_____

Spouse's Employer_____Occupation_____Yrs. On Job_____

Employer Address_____City_____State_____Zip_____

Office Phone_____ Spouse SS#_____ Driver's License#_____

Does your spouse have health insurance at work? Yes_____ No_____ Plan/Group#_____

I/We agree to pay for and understand that full payment of services rendered to the above mentioned patient is due as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor. Insurance Cases: On all insurance the deductible must be met in the beginning unless prior arrangements are made. Should patient default, patient agrees to pay all cost of collection, including collection agency fees, court cost, and reasonable attorney's fees. I request that payment of authorized Medicare benefits, other insurance benefits, or my Attorney, if applicable, be made either to me or on my behalf to Dr. Morton for any services furnished me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, my insurance company or any company liable for payment, any information needed to determine these benefits or the benefits payable for related services.

Patient's or Parent's Signature_____Date_____