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**____________________________