

**Patient Information Sheet**

Patient Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Ins Phone #: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Insured SS#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Certificate Number: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship to Patient

Secondary Insurance: \_\_\_\_\_ Ins Phone #: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Insured SS#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Certificate Number: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship to Patient

*I am aware that Dr Solomon does not participate with any insurance contracts. I understand that Dr. Solomon's office will bill my insurance company as a courtesy for any services rendered to me. I am also aware that any amount not paid by my insurance company is my responsibility.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE**

**PRIMARY PHYSICIAN INFORMATION**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

**REFERRING PERSON/PHYSICIAN**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

**EMERGENCY CONTACT**

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

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

Phone #: \_\_\_\_\_

**Photography Consent**

I authorize the physician, or his assistant, to take photographs. The term “photograph” includes Polaroids, 35mm slides, standard photographs, video tapes, etc. These photographs are the doctor’s property and will be a permanent part of the record. These may be used for teaching, lectures, educational conferences, or publications.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization for payment & release of medical records**

I authorize release of medical records and payment of benefits to the physician and allow a photocopy of my signature to be used to file my insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail/ E-Mail Authorization**