PATIENT INFORMATION SHEET

Patient's Name _____ Date of Birth _____

Street Address _____ Social Security _____

City, State & Zip _____ Home Phone _____

Employer _____ Work Phone _____

Employer Address _____ Cell Phone _____

City, State & Zip _____ Driver's License _____

Insurance Gaurantor Name _____ E-Mail _____

Insurance Gaurantor DOB_____

Spouse's Name _____ Date of Birth _____

Employer _____ Social Security _____

Address _____ Work Phone _____

City, State & Zip _____ Cell Phone _____

In Case of Emergency notify: (if other than spouse)

Name _____ Relationship _____

Phone _____ Address _____

Alt. Phone _____ City, State & Zip _____

Whom May We Thank for your Referral? _____

Please read the following authorization and sign for our file:

I hereby authorize payment directly to Dr. Gary W. Duncan of the medical and surgical benefits otherwise payable to me but not to exceed the charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance. I understand that I will be charged a 30% fee for collections of any unpaid charges.

Signature: _____ Date: _____

I hereby authorize Dr. Gary W. Duncan to release to my insurance company any information required, including the diagnosis and records in the course of my examination or treatment.

Signature: _____ Date: _____