PATIENT INFORMATION FORM

Frank Johnson Jr., M.D.

PATIENT INFORMATION:

FIRST _____ MIDDLE _____ LAST _____ PREFERRED_____

SS#_____/_____/_____ **Date of Birth**_____/_____/_____ **Age**:_____ **Sex**: Male / Female

Permanent Address:_____ City:_____ State:_____ Zip:_____

Marital Status*: **(Circle)*** Single / Married / Divorced / Widow

Employer:_____ City:_____ Phone:_____ Occupation:_____
(indicate if retired)

Preferred Communications: ***(Circle)*** Home / Cell / Work **Email**:_____

Home # _____ / _____ / _____ Cell # _____ /_____ /_____ Work # _____ / _____ / _____

Preferred Pharmacy:_____ City:_____ Cross Roads _____

PRIMARY CARE PHYSICIAN AND EMERGENCY CONTACT:

Primary Care Physician's Name:_____ City:_____ Office Phone #_____/_____/_____

Emergency Contact:_____ DOB:_____ Phone_____/_____/_____ Relationship:_____

INSURANCE INFORMATION:

IF THE PATIENT IS *NOT* THE POLICY HOLDER PLEASE FILL IN THE FOLLOWING:

***Policy Holder's* Name**: Last_____ First_____ Middle:_____

***Policy Holder's* SS#** _____ /_____ /_____ Date of Birth:____/_____/_____ Policy Holder's Phone # _____-_____-_____

***Policy Holder's* Address**:_____ State:_____ Zip:_____

***Policy Holder's* Employer**:_____ Relationship to the patient: Spouse / Mother / Father / Step-Parent / Other

Primary Insurance

Insurance Co Name_____ Co-pay_____

ID #: _____ Group #_____

Secondary Insurance

Insurance Co Name_____

ID #:_____ Group #_____

CURRENT INJURY/CONDITIONS BEING SEEN FOR TODAY:

Body Part Injured/Hurt: **RIGHT** or **LEFT**:_____ Auto Accident? **YES** or **NO** Was this work related? **YES** or **NO**

Date of Injury/Condition Onset:_____ Describe How Injury Occurred:_____

All professional services rendered are charged to the patient. I understand I am responsible for my bill. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance or workman's comp coverage. It is customary to pay for the service when rendered. I hereby authorize Frank Johnson Jr., M.D. to furnish information to insurance carriers concerning my illness/ injury and treatment and I hereby assign to Frank Johnson Jr., M.D. all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount/fees not covered by insurance. In consideration of services rendered (or to be rendered), I agree to pay all accumulated charges not covered by insurance. I permit this authorization to be used in place of the original. I authorize the use of the "signature on file" to be used on all my insurance submissions

SIGNATURE OF PATIENT OR GUARDIAN:_____ DATE:_____