| Patient Information | | | | | |
|---|---|---|---|---|---|
| First | Middle | Last | Social Security Number | Birth Date | Sex |
| Mailing Address | | | City/State | Zip Code | |
| Physical Address | | | City/State | Zip Code | |
| Home Phone | Mobile Phone | Work Phone | Marital Status | | |
| Employer Name | Employer Address | | City/State/Zip | | |
| Employment title | | | Employment Status Please Circle One<br>Retired None Disabled FT PT Casual | | |

| Emergency Contact | | |
|---|---|---|
| Name | Address: | City/State zip: |
| Relationship: | Home Phone: | Mobile Phone: |

| Insurance Information | | |
|---|---|---|
| Primary Insurance Name | ID number | Group Number |
| Insured Name (If insured through spouse, parent, etc.) | | Date of Birth |
| Relationship to patient | Sex | Social Security Number |
| Employer Name/Address/Phone | | |
| Secondary Insurance Name | ID number | Group Number |
| Insured Name (If insured through spouse, parent, etc.) | | Date of Birth |
| Relationship to patient | Sex | Social Security Number |
| Employer Name/Address/Phone | | |

**Staff Use Only** - Does the patient have an advanced directive? _____ Yes _____ No
Patient requests more info? _____ Offered _____ Refused _____ Accepted

**OFFICE POLICY: I understand and agree to the following rules set forth by Barton Health:**

1.) Payment is required at the time of service. If I cannot pay my co-payment, my appointment will be rescheduled.

2.) If I am more than 15 minutes late for an appointment, my appointment will be rescheduled.

**FINANCIAL AGREEMENT AND AUTHROIZATION FOR TREATMENT:**

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees and such other costs as the court determines proper. I hereby assign all proceeds of insurance to this office (a copy of this assignment is as valid as the original.) I authorize the release of all medical information necessary to process any claims on my behalf. I also request payment of medical and/or government benefits to this office.

________________________________________
Patient/Responsible Party Signature

________________________
DATE

**Staff Use Only** - Does the patient have an advanced directive? _____ Yes _____ No
Patient requests more info? _____ Offered _____ Refused _____ Accepted