

Dr. Peter Siroka
PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly we need the following information. All information will be confidential.

PLEASE PRINT!

Name: _____ S.S.N.: _____
Date of Birth _____ Age: _____ Gender: Male _____ Female _____
Address: _____ Apt.# _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Partnered _____
Patient's or Parent's Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Whom may we thank for referring you?: _____
Notify in case of an emergency: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

Primary Insurance

Primary Insurance Name: _____ Primary Insured Name: _____
Relation to Patient: _____ D.O.B.: _____ S.S.N.: _____
Policy #: _____ Group #: _____ Contract #: _____
Address if different from patient: _____
City: _____ State: _____ Zip Code: _____

Additional Insurance

Is the patient covered by another insurance: Yes _____ No _____
If yes name of insurance company: _____ Phone number: _____
Policy #: _____ Group #: _____ Contract #: _____
Subscriber Name: _____ Relation to Patient: _____ D.O. B. _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status I will inform the Doctor.
I authorize my insurance company to pay the Doctor all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the Doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ **Date** _____