**Robert B. Cowan, Jr., M.D.** **Patient Information Form**

New Patient_____ Returning Patient_____ Address Change _____ Date_____

Date of First Visit: _____ Dx Code (office use only):_____

Patient's Name:_____ DOB:_____ Gender: Male____ Female____
(first) (middle / initial) (last)

Address:_____
(Street) (City) (State) (Zip)

Phone: (home)_____ Married ___ Single ___ Divorced ___ Separated ___ Widow(er) ___

(cell)_____ Social Security # :_____

Emergency Contact: _____ Relationship:_____ Phone:_____

Student Status: Non-student ___ Full-time ___ Part-time ___ EMAIL:_____

Patient's Employer:_____ Full-time ___ Part-time ___

Employer's Address:_____ Work Phone: _____
(Street) (City) (State) (Zip)

Patient's Relationship to Policyholder: Self ___ Spouse ___ Child ___ Other Dependent ___ See Card ____

Policyholder's Name_____ DOB:_____ SSN:_____
(first) (middle / initial) (last)

Policyholder's Address:_____ Phone:_____
(Street) (City) (Stat) (Zip)

Insurance:_____ Phone:_____
(Company Name)

Insurance Address:_____
(Street) (City) (State) (Zip)

Insurance ID # / Claim # :_____ Group #_____ Adjuster:_____
(Name, if applicable)

Secondary Insurance:_____ Policyholder:_____
(Company Name)

Secondary Ins Address:_____ Phone:_____
(Stree (City) (State) (Zip)

Sec Ins ID #:_____ Group #:_____

Is Treatment: Work Related _____ Auto Accident Related _____ (State where injury occurred ____ )
Date of Injury:_____

Whom may I thank for referring you? _____Did you visit my website? Yes_____No_____

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***We will be unable to bill your insurance for you unless you agree to the following terms by signing below:***

I understand that I am fully responsible for, and agree to pay promptly all charges for services rendered even if my insurance does not pay, unless my insurance's contract with the provider specifically relieves me of such responsibility. I also understand that I must pay full fee for telephone calls, and for appointments that I fail to keep, or fail to cancel at least 24 hours in advance. (Insurance does not cover phone calls or missed appointments.) I agree that if I do not pay the amount owing, I will be responsible for all costs of collection which may include attorney's fees.

I authorize the billing of my insurance, and the release of any information necessary to process claims.

I authorize my insurance to pay directly to the provider medical benefits for services rendered.

I hereby acknowledge that I have been offered a Notice of Privacy Practices to read.

_____ _____
Patient /Insured's Signature Date Patient/Other Insured's Signature Date