WELCOME TO OUR OFFICE

PATIENT INFORMATION

HOW DID YOU FIRST HEAR ABOUT OUR OFFICE?_____

PATIENT NAME: _____ M F PREFERRED NAME _____

ADDRESS_____ Apt #_____

CITY_____ STATE ____ ZIP CODE _____ HOME PH: ( )_____

BIRTHDATE _____ SSN_____ CELL PH: ( )_____

ARE YOU: __SINGLE __MARRIED __SEPARATED __DIVORCED __WIDOWED EMAIL:_____

EMPLOYER NAME _____ WORK PHONE: ( )_____

EMPLOYER ADDRESS _____ CITY_____ STATE ____ ZIP CODE _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT
(If other than Patient or if Patient is under the age of 18) _____

RELATIONSHIP TO PATIENT _____ HOME PHONE: ( ) _____

ADDRESS_____ CITY_____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER_____

PLEASE LIST FAMILY OR FRIENDS THAT YOU AUTHORIZE US TO RELEASE INFORMATION TO ON YOUR BEHALF:

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

I AUTHORIZE the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim; the payment of benefits to which I am entitled to be made direct to Dr. Lotz; this assignment to remain in effect until revoked by me in writing; a photocopy of this assignment to be considered as valid as an original.

I UNDERSTAND THAT insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment; some companies pay fixed allowances for certain procedures and others pay a percentage of the charge; I am ultimately responsible for all charges whether or not they are paid by my insurance; it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance; all monies paid for materials are non-refundable once the materials have been ordered.

I FURTHER UNDERSTAND THAT a 2% monthly finance charge will be added to all balances that are thirty (30) days past due or greater; if this account is assigned to an attorney or agency for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection; there will be a $50.00 charge for all returned checks.

WE REQUEST THAT CHARGES FOR ALL VISITS BE PAID AT THE CONCLUSION OF EACH VISIT

_____ _____
Signature of Patient (or Parent of Minor) Date

I HAVE REVIEWED THE ABOVE INFORMATION AND VERIFY ALL IS CORRECT.

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