Liberty University Health Services

Patient Information Form

Patient Name (first, last): _____ Date of Birth: ___/___/___

Home telephone: _____ Cell number: _____ Daytime telephone: _____

Email address: _____

Physical address _____ City & State _____ Zip _____

Mailing address _____ City & State _____ Zip _____

Marital Status: S M W D (circle one) Sex: M / F (circle one) SS#: ____ -____-____

Patient's employer: _____ Telephone number: _____

Job Title: _____ May we contact you at work? Yes or No (circle one)

Guarantor Information

Relationship to patient: _____

Guarantor name (first, last): _____ Date of Birth: ___/___/___

SS#: ____ -____-____

Home telephone: _____ Cell number: _____ Daytime telephone: _____

Employer: _____ Work number: _____

Emergency contact information:

Name	Telephone Number	Relationship to Patient

May we leave messages on your home answering machine or with persons that may answer your phone? YES/NO

Billing information – All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the Patient Is Responsible for all fees, regardless of insurance coverage. It is also required to pay copays at the time of service. Self pay patients are expected to pay in full at the time of service unless other payment arrangements have been made with the practice manager.

Insured or Self Pay (circle one). If insured please give insurance card to receptionist.

Primary Insurance Name: _____ Policy # _____ Group# _____
Claims Address: _____ City/State/Zip: _____
Policy Holder's Name: _____ Date of Birth _____
Relationship to Patient: _____

Secondary Insurance Name: _____ Policy # _____ Group# _____
Claims Address: _____ City/State/Zip: _____
Policy Holder's Name: _____ Date of Birth _____
Relationship to Patient: _____

I hereby authorize Liberty University Health Services to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for services rendered for myself and my dependents. I understand that physicians may perform procedures that insurance will not cover and that I am responsible for any amount not covered by insurance.

Date: _____ Signature: _____

Date: _____ Witness: _____