

**PATIENT INFORMATION** (All Information Must Be Completed. Please Print & Sign Where Indicated)  
(Please Use Black Medium Tip Ink Pen Or Gel Tip)

Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_  
City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Area Code Area Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Ethnicity/ Race \_\_\_\_\_ Martial Status \_\_\_\_\_

Drivers License # \_\_\_\_\_ (Please provide Drivers License to Receptionist for copying) State \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY (if different from the patient)**

Name \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_  
City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Area Code Area Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_

**INSURANCE INFORMATION (Please present insurance card once forms are completed).**

*Note: We do not participate, bill or accept payment from Medicaid, Soonercare or Oklahoma High Risk Pool. Tricare is accepted as secondary filing for Medicare only. Otherwise, **WE DO NOT** participate with Tricare insurance..*

**Primary** Insurance Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Name of Employee \_\_\_\_\_

Insured's ID# \_\_\_\_\_

Group # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Relationship of patient to the Insured \_\_\_\_\_

Guarantor Social Sec# \_\_\_\_\_

**Secondary** Insurance Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Name of Insured \_\_\_\_\_

Insured's ID# \_\_\_\_\_

Group # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Relationship of patient to the Insured \_\_\_\_\_

I authorize (BTHD) to leave message regarding appointments and information for treatment, payment or health care operations \_\_\_\_\_ Other family members that are patients \_\_\_\_\_

Pharmacy Address \_\_\_\_\_ Phone \_\_\_\_\_

In case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

May we contact you by email, if so, email address: \_\_\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

In order to establish optimal relation with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time that they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, it is your responsibility to preverify your coverage and you will be asked to pay any unmet deductible, non-covered services and copayments. Any **PATIENT OWED BALANCE** is **DUE IN FULL** at each visit. If these patient responsibilities can not be met, then we will have to reschedule your appointment. **(We reserve the right to charge for missed appointments. Please call at least 48 hours prior to scheduled appointment. A minimum of \$30.00 will be charged for missed medical appointments and \$100 for missed surgical or treatment appointments.)**

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_