Betty Jo Dulaney M.D., P.C.

Patient Information Sheet

Please complete all blanks

PATIENT'S INFORMATION

LAST NAME: ____________________ FIRST: ______________________ MIDDLE INITIAL: ______ D/O/B: __________

ADDRESS: ________________________________ ZIP: __________ S/S/N: _______________ RACE: __________

HOME PHONE: ____________ CELL: _____________ EMAIL _______________ PREFERRED CONTACT:HOME CELL WORK (CIRCLE ONE)

MARITAL STATUS: __________ ARE YOU PREGNANT? ______ WHO REFFERRED YOU TO US?____________________

EMPLOYMENT/SCHOOL (IF APPLICABLE)

EMPLOYER/SCHOOL: ____________________ PHONE: ______________

OCCUPATION: ___________________ CHECK ONE: FULL TIME: ___ PART TIME: ___ [**IF STUDENT CHECK HERE______]**

SPOUSE OR PARENT'S INFORMATION

LAST NAME: ____________________ FIRST: ______________________ MIDDLE INITIAL: ______ D/O/B: _________

ADDRESS: ________________________________ ZIP: __________ S/S/N: _______________ RACE: __________

EMPLOYER: ____________________ OCCUPATION: _________________ PHONE: ________________

IN CASE OF AN EMERGENCY

NAME: _____________________________ DAYTIME PHONE: ________________RELATIONSHIP TO PT: __________

NAME (NOT LIVING WITH YOU): __________________ PHONE: ________________ RELATIONSHIP TO PT: __________

PRIMARY INSURANCE

PLEASE NOTE-THE INSURED IS THE POLICY HOLDER. IF YOU ARE NOT THE POLICY HOLDER, PLEASE LIST THEIR INFORMATION

INS CO: ___________ INSURED NAME: ________________ D/O/B: ______ INSURED'S EMPLOYER: ______________

INS ADDRESS: ___________________ ZIP: ________ PHONE NUMBER: ___________ RELATION TO PT: ____________

POLICY NUMBER: ________________________ GROUP NUMBER: _____________

SECONDARY INSURANCE

INS CO: ___________ INSURED NAME: ________________ D/O/B: ______ INSURED'S EMPLOYER: ______________

INS ADDRESS: ___________________ ZIP: ________ PHONE NUMBER: ________________

POLICY NUMBER: ________________________ GROUP NUMBER: _____________

PLEASE READ AND SIGN

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. DULANEY AND I AUTHORIZE DR. DULANEY TO RELEASE ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT AS REQUIRED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES AT THE TIME SERVICES ARE RENDERED INCLUDING ANY CHARGES IN EXCESSOF MY INSURANCE RESONABLE AND CUSTOMARY, WHETHER OR NOT THEY ARE COVERED BY MEDICARE OR ANY OTHER INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR VERIFY MY INSURANCE COVERAGE AND PRE-CERTIFYING MY BENEFITS WITH MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COLLECTION COST AND/OR ATTORNEY FEES INCURRED IN THE COLLECTION OF THIS ACCOUNT. I GIVE PERMISSON TO DR. BETTY JO DULANEY M.D., P.C. FOR MEDICAL TREATMENT INCLUDING, BUT NOT LIMITED TO, EXAMINATION, INJECTIONS, BLOOD TEST, DIAGNOSTIC TESTING OR MEDICAL PROCEDURES DEEMED NECESSARY FOR DIAGNOSIS AND TREATMENT. I HAVE ALSO READ AND UNDERSTAND THE PATIENT RIGHTS AND RESPONSIBILITIES, AS WELL AS THE HIPPA GUIDELINES AND I UNDERSTAND THAT A COPY IS READILY AVAILABLE UPON MY REQUEST. FURTHERMORE, I VERIFY THAT THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: X ______________________________ **DATE:** ___________

SIGNATURE OF PARENT IF PATIENT IS A MINOR: X ______________________________ **DATE:** ___________