

CONFIDENTIAL PATIENT INFORMATION FORM

Today's Date: _____

NAME: _____ Home Phone: _____ Work # _____ Cell # _____

Home Address: _____ City _____ Zip: _____ How Long? _____

DATE of BIRTH: _____ AGE: _____ M: ___ F: ___ Marital Status S M W D # of Children _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

Your Employer: _____ Address: _____ City _____ State/Zip _____

Your Occupation: _____ Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Address: _____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT: _____

Check Which One/If Any that Applies: On the job injury (L&I) _____ or AutoAccident _____

INSURANCE INFORMATION

Name of Insurance Company and Policy #

In Case of Emergency (name of relative or close friend NOT living in your home)
Name: _____ Address: _____ Phone#: _____

I understand and agree that Health and Accident Insurance policies are an arrangement between an Insurance Carrier and Myself. Furthermore, I understand that Drs. Snyder will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to Drs. Snyder will be credited to my account upon receipt. However, I clearly understand that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I agree also, that Drs. Snyder may impose reasonable interest late charges, cost, and/or reasonable attorney's fees should my account become delinquent. I agree that any lawsuit for collection of my account may be brought in Spokane County, Washington.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

PATIENT'S SIGNATURE _____ DATE: _____