PATIENT INFORMATION

Last Name: First: MI: Nickname:
Social Security Number: Date of Birth: / /
Mailing Address Physical/Local Address ❑ Same as mailing address
Street:
City: State: City: State:
Zip Code: Zip Code:

Please enter telephone number and place ✓ mark in the box next to the phone # you prefer us to call first.

❑ Home Phone ❑ Day Phone: ❑ Other Phone:

EMPLOYMENT INFORMATION

Employer: ❑Not employed ❑ Retired
Employer Address:
City: State: Zip: Work Phone:

INSURANCE INFORMATION

Please have the receptionist scan your insurance card. If your insurance card is not current or available, the patient may be billed.

Name of Insurance:
I am the policy holder (subscriber) of this insurance on this card ❑
My spouse ❑ Mother ❑ Father ❑ Other❑ is the policy holder for the insurance on this card.
Employer of Policy Holder: Cardholder's Social Security #:
Name of Policy Holder (if different than patient): Date of Birth:
Mailing Address (if different than patient): City: State: Zip:

GUARANTOR INFORMATION-Person Responsible for Payment ❑ Self, if not self fill in spaces below

Last Name: First: MI:
Date of Birth: / / Relationship to Patient: ❑ Spouse ❑ Parent ❑ Other
Mailing Address: (If different than patient) City: State: Zip:
Home Phone Number: Day/Work Phone Number:

EMERGENCY CONTACT INFORMATION: ❑ None ❑ Guarantor ❑Other, if other fill in space below

Name: Relationship:
Home Phone Number: Day/Work Phone Number:

PAYMENT OF BENEFITS AND INFORMATION RELEASE:

I request that payment of authorized insurance benefits be made on my behalf to Dr. Troy Norton for any services furnished to me by Dr. Norton. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services by Dr. Troy Norton.

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received or been offered a copy of Dr. Troy Norton's Notice of Privacy Practices.

SIGNATURE:

By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

_____ _____

Patient/Guardian signature *Date*