Patient Information

Today's Date:________________

First Name:______________________ Initial ____ Last Name: ___________________________

Nickname: ______________________ Gender: ____ Male ___ Female

Birth Date:______________ Current Age: _______Social Security #: ________________________

Home Address:____

____

Home Phone: ________________________ Mobile Phone: ______________________________

Email Address: _______________________

Employer: __________________________ Occupation: ___________________________________

Work Phone: __________________ Work Email: ____

Primary Physician: ___________________________Phone: _________________________________

Emergency Contact: Name:_________________________ Phone: __________________________

Whom can we thank for referring you? ____

Please read the following statement before signing:

I, the undersigned, understand that payment in full is expected at the time of service, including all co-pay amounts for insurance billing. I authorize treatment of the person names above and agree to pay all fees for such treatment. I have been informed of Dr. Simon's fees for services. I hereby authorize Dr. Simon to receive all benefits to which I and/or my dependents are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment of any of my charges. I have also been informed of the $35.00 fee (per RCW 62A, 3-515 & 520) on all checks returned from my bank NSF.

The undersigned agrees that whether she/he signs as an agent, that she/he is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned is able to pay in full within thirty days, a $5.00 per/visit/per month fee will applied (per RCW 19.52).

Signature________________________ Name (printed): _________________________