

PATIENT INFORMATION

Patient Name: _____ Home Phone: _____

May we send appointment reminders via text message? Yes No Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SS# _____ Date of Birth: _____ Age: _____ Sex: M F

Marital Status: S M W D Email Address: _____

Employer: _____ Occupation: _____ Phone: _____

Spouses Name: _____ Phone: _____

Cell Phone: _____

Additional/Emergency Contact: _____ Relationship: _____

Phone: _____

How Did You Hear About Dr. Reath? _____ Reason for Visit: _____

RESPONSIBLE PARTY (if patient is a minor)

Name: _____ Phone: _____

Address: _____ Cell Phone: _____

City: _____

State: _____ Zip: _____ Relationship: _____

PLEASE PROVIDE RECEPTIONIST YOUR INSURANCE CARD TO COPY

Name of Insurance Company: _____

Person on Insurance Card (if other than patient):

Name: _____ Date of Birth: _____ SS# _____

Release to Insurance/Assignment of Benefits:

I hereby authorize payment directly to Dr. David B. Reath of any medical or surgical benefits to which he may be entitled under my medical and surgical plans. I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I also give authorization for Dr. Reath to release necessary medical information to my insurance carrier(s).

Signature: _____ Date: _____