Patient Information
Please Print

Name:____
LAST FIRST MIDDLE

D.O.B.____________Social__________________Age________Marital Status_______

Cell Phone:____________________Alternate Phone:______________________

Address:____
STREET CITY STATE ZIP CODE

E-Mail Address____

Patient's Job Description____________________________Employer_______________

Spouse:____________________________Spouse D.O.B.__________________

Spouse Job Description_____________________________Employer_______________

Emergency Contact:_________________________Phone #:______________________

Insurance Information

Primary Insurance:__________________________Insured's D.O.B.________________

Insured's Social:______________________Insured's Name:______________________

Secondary Insurance_________________________Insured's D.O.B.________________

Insured's Social:______________________Insured's Name:______________________

Medical Information

Why are you seeing Dr. Fite today?____

Name of person who referred you?____

I authorize Dr. J. Michael Fite M.D. as of this date and all future visits to diagnosis and treat any condition I may have. I also consent for the use and disclosure of protected health information for the purposes of treatment, payment and health care operations. I further authorize payment for these claims to be sent directly to J. Michael Fite, M.D.

____
Signature Date

Please present your insurance card at the front desk. Thank you!