

Patient Information Form

Patient Name: (Last) _____ (First) _____ (MI) _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Beeper/Cellular: _____

Email Address: _____

Birth date: _____ Age: _____ Sex: M F

Country of Birth: _____ Country of Parents' Birth: _____

Education: *Elementary *High School/Technical School *2-yr College *4-yr College
*Graduate School

(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Ext. _____

Social Security (optional): _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Primary Care Physician: _____ **Phone:** _____

Referred by (if different from above): _____

Financial Policy:

Thank you for selecting Howard University for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, money orders, checks, and cash.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature Date