# CONFIDENTIAL PATIENT INFORMATION

*(Please complete this form and bring it with you to your appointment. Thank you!)*

Dr. Conan Shaw

667 Castle Creek Drive Seven Fields, PA 16046 drshaw@zoominternet.net (724) 778-3000

# Name Home Phone

**Street Address**

**City State Zip**

**Age Birth Date Marital Status M S W D / Children**

**Daytime Phone Number Cell Phone**

**Name of Spouse / Partner**

**Email Address**

**Emergency Contact Phone**

**Referred By**

**Purpose of this Appointment**

**Office Policies**

* Our office accepts cash, check and major credit cards excluding American Express. Payment is due at the time services are rendered.
* We respect our patients’ time and adhere to our appointment schedule. Please arrive at least 5 minutes prior to your scheduled appointment time.
* In cooperation with office policy; we require a 24 hour notice to change or cancel an appointment, or office visit charge will be processed.

I understand that health insurance policies are an arrangement between the insurance carrier and myself. I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company. And that any amount authorized to be paid directly to the office will be credited to my account upon receipt. However, I understand that all services rendered to me are charged directly to me and that I am personally responsible for my care and payment. If unpaid accounts necessitate collections, the cost of the collection agency will be added to my unpaid bill

**Patient Signature Date Parent/Guardian’s Signature**

**Authorizing Care Date**