

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Guardian's Name (if minor): _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers (please provide the numbers you would like to be reached at):

Home: _____

Work: _____

Mobile: _____

Email: _____ (please complete the
Email Contact Consent form, if you wish to use email as a form of communication)

Date of Birth: _____ Social Security Number: _____

Emergency Contact: _____ Relationship: _____

Phone Number(s): _____

Primary Medical Doctor's Name: _____

Doctor's Telephone Number: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Prescription Benefit Coverage/Insurance: _____

ID Number: _____ Phone Number: _____

Referred By: _____

Treatment Agreement:

- 1) I have reviewed the policies/procedures and rates/insurance information provide on Dr. Cowan's website. I know I can ask for a hard copy of this information.
- 2) I understand that Dr. Cowan does not participate with any insurance plans.
- 3) I understand that Dr. Cowan does not participate with Medicare, and if I am covered by Medicare, I must complete the Medicare Private Contract from and agree not to submit claims for my care.
- 4) I understand that payment is due at the time of service.
- 5) I understand that if I cancel an appointment with less than 48 hours notice, I will be charged for the full appointment.

Patient (or Guardian) Signature

Date