FUELLING & ASSOCIATES, LLC
407 E. Russell Rd., Bldg. A, Ste. 5
P.O. Box C
Warrensburg, MO 64093-3107
(660) 429-6678

❑ Warrensburg
❑ Clinton
❑ Warsaw

PATIENT DATA FORM

Date: _____ Home Phone: (_____) _____
❑ Change Cell Phone: (_____) _____

For Office Use Only
Med. Record # _____
Date Entered _____

PATIENT INFORMATION

Name _____ Soc. Sec. _____
Last Name First Name Middle Initial
Address _____ City _____ State _____ Zip Code _____
Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (_____) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (_____) _____

FINANCIALY RESPONSIBLE PERSON(S)

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone (_____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (_____) _____

PRIMARY INSURANCE

Subcriber Name _____ Birthdate _____ Relation to Patient _____
Address (if different from patient's) _____ Phone (_____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (_____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____
Birthdate _____ Relation to Patient _____
Insurance Company _____
Soc. Sec. # _____ Ins. Phone # _____
Contract # _____ Group # _____
Subscriber # _____

Subscriber Name _____
Birthdate _____ Relation to Patient _____
Insurance Company _____
Soc. Sec. # _____ Ins. Phone # _____
Contract # _____ Group # _____
Subscriber # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Fuelling & Associates, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named facility may use my leath care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I agree to notify F&A, LLC immediately of any changes in address or insurance coverage or I will be responsible for any resulting uncovered services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient