



Royal Center
for Advanced Medicine

PATIENT INFORMATION /FINANCIAL RESPONSIBILITY

Name: _____

Date of Birth: ____/____/____ Sex: _____

SSN: ____--____--____ Ht: _____ Wt: _____

Street: _____

City: _____ St: _____ Zip: _____

Phone: Home (____) _____ Cell (____) _____

Fax: (____) _____

Email: _____

Occupation: _____

Employer: _____ Phone: (____) _____

Street: _____ City: _____ St: _____ Zip: _____

Allergies: _____

Surgeries: _____

Implants: _____ Other Cautions: _____

Other Contact: _____ Relationship to Patient: _____

Contact's phone: Home (____) _____ Cell (____) _____

FINANCIAL Billing Address and Telephone:

Street: _____ City: _____ St: _____ Zip: _____

Home: (____) _____

I certify that I am the patient, or duly authorized general agent of the patient authorized to furnish the information requested, and have completed this form fully and completely. I give permission for my/the patient's picture to be taken and stored with the medical record. I understand that **PAYMENT IS DUE WHEN SERVICES ARE RENDERED** and even though I may have insurance coverage, I am personally responsible for the payment for all services in full. Returned checks are subject to a \$25 service fee. In the event that either checks for payment are insufficient or fraudulently written, or that unpaid debt must be pursued, I will also be responsible for any legal, banking, interest, and/or collection fees that may be incurred during the process to resolve.

(Patient or Agent's Signature)

(Date)