PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

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

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

Emergency Contact: _____ Relationship: _____
Phone Number(s): _____

Primary Medical Doctor's Name: _____
Doctor's Telephone Number: _____

Pharmacy Name: _____ Pharmacy Address:_____

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