Dr. Conan J. Shaw
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Seven Fields, PA 16046
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(724) 778-3000

CONFIDENTIAL PATIENT INFORMATION

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

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 ____

Patient's Nearest Relative ________________________________ **Phone** ________________

Referred By ____

Purpose of this Appointment____

Office Policies

- Our office accepts cash, check and major credit cards. 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 our scheduling, to change or cancel an appointment, please contact the office with at least 24 hours notice.

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**_________________