PATIENT INFORMATION

Thank you for choosing our office for your medical care! In order to serve you properly, we request the following information. Please print. All information is *strictly confidential*.

Date ________ Patient Name ____________________ Patient # ________
LAST MIDDLE INITIAL FIRST

Birthdate ____________ ☐ MALE ☐ FEMALE SSN ____________ Home Phone ____________

Address ____________ City ____________ State ______ Zip ________

Check appropriate box: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐ MINOR

Patient's Employer ____________ Work Phone ____________

Business Address ____________ City ____________ State ______ Zip ________

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

If patient is a student, name of school/college ____________ City ____________ State ________

Whom may we thank for referring you? ____________ Your E-mail ____________

Emergency Contact Person ____________ Phone ____________

Responsible Party

Name of person responsible for this account ____________ Driver's License # ____________

Relationship to Patient ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER Birthdate ____________ Home Phone ____________

Address (if different from Patient) ____________ City ____________ State ______ Zip ________

Employer ____________ Work Phone ____________

Is this person currently a patient at our office? ☐ YES ☐ NO

Insurance Information (do not complete this section if insurance coverage is not expected)

Name of Insured ____________ Employment Date ____________

Relationship to Patient ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER Birthdate ____________ Home Phone ____________

Name of Employer ____________ Work Phone ____________

Address of Employer ____________ City ____________ State ______ Zip ________

Insurance Company ____________ Policy # ____________ Group # ____________

Address of Insurance Company ____________ City ____________ State ______ Zip ________

How much is your deductible? $________ How much have you used? $________ Maximum Annual Benefit $________

Do you have any additional insurance? YES NO If 'YES', please complete the following:

Name of Insured ____________ Employment Date ____________

Relationship to Patient ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER Birthdate ____________ Home Phone ____________

Name of Employer ____________ Work Phone ____________

Address of Employer ____________ City ____________ State ______ Zip ________

Insurance Company ____________ Policy # ____________ Group # ____________

Address of Insurance Company ____________ City ____________ State ______ Zip ________

How much is your deductible? $________ How much have you used? $________ Maximum Annual Benefit $________

I certify that the above information is accurate to the best of my knowledge. I have read and signed the forms "FINANCIAL POLICIES" and I further authorize consent to treat.

X ____________________ ____________________

Signature Of Patient or Parent if Minor Date