

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly and efficiently we need the following information.

Please print clearly ~ All information will be confidential

Patient Name (Last, First, M.I.): _____ Date: _____

SS#: _____ Birthdate: _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Please circle one: Minor Single Married Divorced Widowed Separated

Patient/Guardian's Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

If patient is a student, name of school/college: _____ City: _____ State: _____

Emergency Contact Name & Phone: _____ Relation to Patient: _____

Referring Physician: _____ City: _____ Phone: _____

Other Referral(s): _____

Responsible Party

Name of person responsible for this account: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Driver's License #: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured: _____ Relation to Patient: _____

SS#: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

How much is your deductible? _____ How much is your office visit co-pay? _____ Specialty Physician co-pay? _____

Secondary Insurance Information

Name of insured: _____ Relation to Patient: _____

SS#: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

How much is your deductible? _____ How much is your office visit co-pay? _____ Specialty Physician co-pay? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of patient or parent/guardian of minor

Date