PATIENT INFORMATION (Confidential)

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

E-Mail_____ Cell Phone_____ Home Phone_____

SSN_____ Birth Date_____

Check Appropriate Box: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

If college student, FT/PT, Name of School _____ City_____ State_____

Patient's or Parent's/Guardian's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent's/Guardian's Name_____ Employer_____ Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency?_____ Phone_____

RESPONSIBLE PARTY

Name of person responsible for this account_____ Relationship to patient_____

Address_____ Home Phone _____

Driver's License #_____ Birth Date_____ SSN_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ◯ Yes ◯ No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient_____

Birth Date_____ SSN_____ Date Employed_____

Name of Employer_____ Union of Local #_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co._____ Phone_____ Group#_____ Policy ID_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max Annual benefit?_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of insured _____ Relationship to patient_____

Birth Date_____ SSN_____ Date Employed_____

Name of Employer_____ Union of Local #_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co._____ Phone_____ Group#_____ Policy ID_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max Annual benefit?_____

X _____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN PATIENT NUMBER