Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please PRINT. All information will be confidential.

Date_________________________SS#_________________________

Name: Last_________________________ First_________________________ M.I.__________

Birthdate_________________________ Home Phone_________________________

Address _________________________

City_________________________ State_________________________ Zip_________________________

Check Appropriate Box

❒ Minor ❒ Single ❒ Divorce ❒ Widowed ❒ Separate ❒ Married

Patient's or Parent'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? _________________________

Person to contact in case of emergency _________________________Phone_________________________

Responsible Party

Name of person responsible for this account_________________________Relationship to patient_________________________

Address_________________________

Home Phone _________________________ Work Phone _________________________

Employer _________________________

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

Insurance Information

Name of Insured _________________________ Relationship to Patient _________________________

Birthdate _________________________ Social Security Number _________________________

Date Employed _________________________ Insurance Company _________________________

Group Number _________________________ Union or Local # _________________________

Ins. Co. Address _________________________

City _________________________ State_________________________ Zip _________________________

How much is your deductible? _________________________ How much have you used? _________________________

Ins. Co. Phone # _________________________

I authorize the 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.

X_________________________

Signature of patient or parent if minor