PATIENT INFORMATION – CONFIDENTIAL

PLEASE PRINT

Date:

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____

Check one: ____Minor ____ Single ____ Married _____ Divorced _____Widowed _____Separated

Patients or Parents Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parents name _____ Employer _____ Work Phone_____
If Patient is a student, Name of School/College _____
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 _____ Patients Social Security #_____
Address of Responsible Party _____ Home Phone _____
Driver License # _____ Birthdate _____
Employer _____ E-Mail address _____
Pharmacy _____ Pharmacy Phone # _____
Is this person currently a patient in our office? ____Yes ____No

Insurance Information

Name of Insured _____ Relationship to patient _____
Birthdate _____ Social Security#_____ Date Employed _____
Name of Employer _____ Work Phone #_____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Co _____ Group #_____ Union/Local# _____
Insurance Co Address_____ City _____ State_____ Zip _____
How much is your deductible?_____ How much have you used ?_____Max annual benefit_____

Do You Have Any Additional Insurance – If yes complete the following

Name of Insured _____ Relationship to patient _____
Birthdate _____ Social Security Number _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union/Local # _____
Insurance Co Address _____ City _____ State _____ Zip _____
How much is your deductible?_____ How much have you used ?_____Max Annual Benefit?_____

_____ **(SIGNATURE)**

SIGNATURE OF PATIENT OR PARENT IF MINOR