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 ___________ Patient Name____ Patient #__________
SSN__________________ ☐Male ☐Female Birthdate ___________ Home phone _______________________
Address ________________________________ City _______________________ State ______ Zip _______
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent's employer ______________________________________Work phone ________________
Business address ____
City _______________________________________ State______________________ Zip _______________
Spouse or parent's name ________________________________ Work phone ________________________
If patient is a student, name of school/college ____
City _______________________________________ State _____________________ Zip _______________
Whom may we thank for referring you? ____
Primary Care Physician ____ phone # _______________

Contact Information

May we leave a message on voicemail or answering machine? At home ______ At work _______
May we leave a message at your home with other residents? _____
Who may we talk to about your medical concerns? _____________________ Phone: ____________________
Relationship to patient? ________________ Is this contact for emergency purposes only? _______________

Insurance Information

Name of insured _____________________________________ Relationship to patient _________________
Birthdate ___________________ SSN ______________________ Date employed ______________________
Name of employer ____ Work phone __________________
Address of employer ____
City _______________________________________ State ______________________ Zip ______________
Insurance company ____________________________ Group # _____________ Union or local # ________
Ins. Co. address ____
City _______________________________________ State _____________________ Zip _______________
How much is your deductible? _________________ How much have you used? _______________________

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

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Name of insured _____________________________________ Relationship to patient _________________
Birthdate ___________________ SSN ______________________ Date employed ______________________
Name of employer ____ Work phone __________________
Address of employer ____
City _______________________________________ State ______________________ Zip ______________
Insurance company ____________________________ Group # _____________ Union or local # ________
Ins. Co. address ____
City _______________________________________ State _____________________ Zip _______________
How much is your deductible? _________________ How much have you used? _______________________

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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 otherwise payable to me directly to the doctor.

X ____ ___________________________

Signature of patient or parent if minor Date