

**PATIENT INFORMATION (CONFIDENTIAL)**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX: MALE ( ) FEMALE ( )

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

IF COLLEGE STUDENT, F.T./PT., NAME OF SCHOOL \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

**RESPONSIBLE PARTY**

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL# \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMP ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ TEL# \_\_\_\_\_ GRP# \_\_\_\_\_ POLICY/I.D.# \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL# \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMP ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ TEL# \_\_\_\_\_ GRP# \_\_\_\_\_ POLICY/I.D.# \_\_\_\_\_

INS.CO.ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR PARENT IF MINOR**

E-MAIL: \_\_\_\_\_