

**Patient Information**

*Thank you for choosing our practice. Please complete this form in ink and print your answers.  
If you have any questions, please do not hesitate to ask one of our staff.*

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name MI Last Name

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Home Phone# (\_\_\_\_) \_\_\_\_\_

Cell Phone# (\_\_\_\_) \_\_\_\_\_ Work Phone# (\_\_\_\_) \_\_\_\_\_

Where do you prefer to take calls:  Home  Cell  Work

May we contact you by E-mail?  Yes  No E-mail Address \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Workplace \_\_\_\_\_

If you are a student, name of school \_\_\_\_\_ City/State \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Closest relative not living with you & their phone number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_

**Responsible Party (if patient is a minor)**

Name of person financially responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address of Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Information**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone # (\_\_\_\_) \_\_\_\_\_

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

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone # (\_\_\_\_) \_\_\_\_\_