Patient Information

Date____________

Name_______________________________________ Date of Birth____________ Sex: M F

Address_______________________________ City______________________ St _________Zip_______

Daytime Phone________________ Evening Phone ___________________Cell___________________

Social Security# or insurance ID _________________ E-mail ________________________________

(Circle one) Minor Single Married (if married name of spouse) _____________________

Whom may we discuss medical/billing information about you with? _____________________

Employer___________________________ Primary Care Physician________________________

Occupation: ____

Referred by____________________ Emergency Contact ____________________Phone____________

Responsible Party

(who is responsible for the account if different than above)

Name____Relationship__________________________

Date of birth_____________ Social Security #____

Address ________________________________ City__________________ St________ Zip_________

Employer __________________________________ Address_________________________________

Daytime Phone________________ Evening Phone ___________________Cell___________________

Insurance Information

Primary Policy Holders Name _______________________________ ID# _______________________

Date of Birth ______________ Employer__________________ Relationship to Patient_____________

Secondary Policy Holders Name_______________________________ ID# ______________________

Date of Birth ______________ Employer__________________ Relationship to Patient_____________

By signing this form you are verifying that the above information is correct and assuming responsibility for payment of the account balance in full.

Signature of Responsible Party____ Date_____________