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. Filing claims to your insurance is a courtesy. If you are unable to fill this out entirely, we may refuse to file claims for you and payment will be due same day.

Date_____Patient Name_____

SSN_____DOB_____State of birth_____ ☐ Male ☐ Female

Address_____ City_____ State_____ Zip_____

Home phone_____ Cell phone_____ Can we call your cell phone? _____

Email address_____ May we email medical correspondence? _____

Please check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Other

Race_____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Mother's maiden name_____

Employer_____ Work phone_____

Person to contact in case of an emergency_____Relationship to you_____

Address_____ Phone # _____

Preference for appointment confirmation for future use - Phone call_ _ Text _ _ Email _ _

Where did you first hear of our practice_____

RESPONSIBLE PARTY

Name of person responsible for this account if not patient_____

Relationship to patient_____Address if different from patient_____

City_____ State_____ Zip_____ Phone number _____

INSURANCE INFORMATION

Primary insurance_____

Name of insured_____Relationship to patient_____

Date of birth_____ Social security number_____ Group number_____

Secondary insurance_____

Name of insured_____Relationship to patient_____

Date of birth_____ Social security number_____ Group number_____