

## 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\_\_\_\_\_