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_________