



Welcome!

Patient Information (Confidential)

Name (first,middle,last) _____ I Prefer to be called: _____
Address: _____ City: _____ State: _____ Zip _____
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
The best time to contact me is: _____ A.M. P.M. on my Home phone Work phone Cell
Date of Birth: _____ Social Security Number: _____
Check Appropriate Box: Minor Single Married Widowed Separated Divorced
If Student, Name of School _____ City/State _____ FT PT
Spouse or Parent's Name: _____ Employer _____
Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
Email Address _____
Drivers License # _____

Responsible Party

Relationship to Patient: Self Spouse Parent Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer _____ Work Phone (____) _____
SSN# _____ Date of Birth _____

Insurance Information

Name of Insured _____ DOB _____ Relationship to Patient _____
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City _____ State: _____ Zip _____
Insurance Company _____

----- DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING -----

Name of Insured _____ DOB _____ Relationship to Patient _____
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City _____ State: _____ Zip _____
Insurance Company _____