Date:_____

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. All information will be confidential. PLEASE PRINT!

Patient Name:_____ Date of Birth:_____
SSN:_____ Driver's License# _____State_____
Please circle: Male/Female
Circle Appropriate: Single Married Divorced Widowed Separated
Address_____
City_____ State:_____ Zip:_____
Home #_____ Cell#_____ Other:_____
Employer_____ Work # _____
Person to Contact in case of Emergency:_____ Phone#_____
Referring Physician:_____
Primary Care Physician: _____

Responsible Party if Patient is a minor:
Parent/Guardian Name:_____ Relationship to Patient:_____
Date of Birth:_____ SSN:_____
Driver'sLicense#_____Address_____
City_____ State:_____ Zip:_____
Home #_____ Cell#_____ Other:_____
Employer_____ Work # _____

Insurance Information-Please attach copy of card(s)
Complete the following only if insurance is through someone other than patient (i.e. spouse, parent, other)

Primary Insurance:
Name of Policy Holder:_____ Relationship to patient:_____
Date of Birth:_____ SSN#_____
Name of Employer:_____ Work Phone:_____
Insurance Company: _____ Group Number:_____
Insurance Company Telephone Number:_____

Secondary Insurance:
Name of Policy Holder:_____ Relationship to patient:_____
Date of Birth:_____ SSN#_____
Name of Employer:_____ Work Phone:_____
Insurance Company: _____ Group Number:_____
Insurance Company Telephone Number:_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of patient or parent/guardian if minor:_____
Date:_____ Revised 9/06