PATIENT INFORMATION — CONFIDENTIAL

Welcome!

Date _____

Name _____
first middle last preferred

Address _____ **Drivers license #** _____

City _____ **State** _____ **Zip** _____

Soc. Sec.# _____ **Birth Date** _____ **Age** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Contact Information

Home (____)_____ Work (____)_____

Mobile (____)_____ Fax (____)_____

E-mail _____

In the event of an emergency, who should we contact?

Name _____

Relationship _____

Work Phone (____)_____ Home Phone (____)_____

How did you hear about us?

☐ Sign or Store Front
☐ Yellow Book
☐ Family
☐ Friend _____
☐ Website
☐ Mailing which? _____
☐ Other _____
_____

Employer _____ **Occupation** _____

or

Name of school/college _____ **City** _____ **State** _____ **Zip** _____

RESPONSIBLE PARTY

Who is responsible for this account? _____ **Relationship** _____

Address _____

City _____ **State** _____ **Zip** _____

Birth Date _____ **Home Phone** (____)_____ **Work Phone** (____)_____

Soc. Sec.# _____ **Are they a patient here?** ☐ **Yes** ☐ **No**

Is there anyone else we are allowed to contact regarding your treatment? If so, please list name and number

Name_____ **Number**_____

INSURANCE INFORMATION

Name of insured _____ **Relationship** _____**Employer**_____**DOB**_____

Soc. Sec.# _____ **Ins. Company** _____ **Ins. ID** _____ **Group #** _____

Do you have any secondary insurance? ☐ **Yes** ☐ **No** **If yes, complete the following?**

Name of insured _____ **Relationship** _____**Employer**_____**DOB**_____

Soc. Sec.# _____ **Ins. Company** _____ **Ins. ID** _____ **Group #** _____