



Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ [] Male [] Female
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone/Pager _____ SS# _____
E-Mail Address: _____
Check Appropriate Box: [] Minor [] Single [] Married [] Divorced [] Widowed [] Separated
Patient's or Parent's Employer _____ Work Phone () _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone () _____
If Patient is a Student, Name of School/College _____ City _____ State _____
How did you find out about our office? _____
Person to Contact in Case of Emergency _____ Phone () _____

RESPONSIBLE PARTY

Name of Person _____ Relationship
Responsible for this Account _____ to Patient _____
Address _____ City _____ State _____ Home Phone () _____
Social Security # _____ Birthdate _____
Employer _____ Work Phone () _____
Currently a Patient in our Office? [] yes [] no

Insurance Information

Name of Insured _____ Relationship
to Patient _____
Birthdate _____ Insurance I.D. # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone# _____ Group # _____ Union/Local # _____
Address _____ City _____ State _____ Zip _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Secondary Insurance Information

Name of Insured _____ Relationship
to Patient _____
Birthdate _____ Insurance I.D. # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone # _____ Group # _____ Union/Local # _____
Address _____ City _____ State _____ Zip _____

