



Date \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ [ ] Male [ ] Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_ SS# \_\_\_\_\_  
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 \_\_\_\_\_  
How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit? \_\_\_\_\_

