

PATIENT INFORMATION**CONFIDENTIAL***Welcome!*

Date _____

Name _____
first middle last preferred

Address _____

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**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 # _____