PATIENT INFORMATION

Patient Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip _____

(circle preferred method of contact) Home phone # _____ Cell phone # (or text) _____ E-mail address _____

Social Security # _____ Date of Birth _____ Sex: Male ☐ Female ☐

Employer _____ Occupation _____ Work phone# _____

Marital Status: Married ☐ Single ☐ Other ☐ Referred by: _____

Spouse Name _____ Occupation _____ Work phone # _____

Person to call in case of emergency _____ Relationship _____ Phone # _____

INSURANCE

Insurance Company Name _____ Policy or Group # _____

Policy Holder (Subscriber) _____ Patient's Relationship to Subscriber _____

If different from above: Subscriber's Social Security # _____ Subscriber's Date of Birth _____

SECONDARY INSURANCE

Insurance Company Name _____ Policy or Group # _____

Policy Holder (Subscriber) _____ Patient's Relationship to Subscriber _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

IF CHILD

Father or Mother's Last Name _____ First Name _____ M.I. _____ Phone # _____

Father or Mother's Social Security # _____ Employer _____ Work phone # _____

****The guardian who requests treatment for the child is responsible for all fees for services rendered****

I understand that payment is expected on the day services are rendered. I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

Signature of Patient or Responsible Party _____ Date _____