

WELCOME TO OUR OFFICE

Please complete the form below.

PATIENT INFORMATION

Last Name _____ First _____ Middle _____ Date _____

Address _____ City/State _____ Zip _____

Phone () _____ Cell # _____ Social Security # _____

Date of Birth _____ Age _____ Sex _____ Marital Status: M S W D

Race _____ Ethnicity _____ Primary Language _____

(circle one) Employed / Student / Retired / Unemployed

Place of Employment _____ Address _____

Work Phone () _____ Type of Work _____

Spouse's Name _____ Employer _____ Phone _____

Primary Physician _____ Phone # _____ Last visit _____

In case of emergency, who should be notified? _____

Relationship _____ Phone _____

If patient is a minor: Parent/Guardian Name _____

Address _____ City/State _____ Zip _____

Phone () _____ Social Security # _____

Date of Birth _____ Age _____ Sex _____ Marital Statue: M S W D

Parent's Employer _____

INSURANCE INFORMATION

Name of Insurance Co. _____ Policy ID# _____ Group # _____

Address _____ City/State _____ Zip _____

Name of Insured _____ Relationship _____

Insured Date of Birth _____ Social Security # _____

Additional Insurance:

Name of Insurance Co. _____ Policy ID # _____ Group # _____

HOW DID YOU HEAR ABOUT US? (circle or fill in)

Newspaper Live in the area Saw office sign Phone book Other _____

Who may we thank for the referral? _____

I request that payment of authorized Medicare/other insurance company benefits be made to this practice for any services furnished to me by this practice. Regulations regarding Medicare assignment of benefits apply. I further authorize the release of medical information by this practice to the Social Security Administration, Health Care Financing Administration or its intermediaries, of any other insurance company with which for health care benefits may be filed. Finally, I understand the fact that the ultimate responsibility for all charges incurred on my account is mine & agree to pay all deductible, coinsurance charges, & charges for non-covered services.

Patient's or Guardian's Signature _____ Date _____