

### Patient Information

Date \_\_\_\_\_ Best Phone # to be Contacted at: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Sex:  M  F  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Responsible Party Information

Father's Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Mother's Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

### Insurance Information

Primary Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_  
Last First Middle

Insured's Address \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Street City State Zip

Insured's Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_  
Street City State Zip

Insurance Co. Phone No. \_\_\_\_\_ Group No. \_\_\_\_\_

Do you have dual coverage?  Yes  No

Secondary Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_  
Last First Middle

Insured's Address \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Street City State Zip

Insured's Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_  
Street City State Zip

Insurance Co. Phone No. \_\_\_\_\_ Group No. \_\_\_\_\_

### Emergency Information

Name of nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_  
Last First Middle

Complete Address \_\_\_\_\_  
Street City State Zip

I agree to pay the estimated patient portion at the time of service and will be financially responsible for any portion not paid by the insurance company.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

