

**Welcome! Thank you for selecting us.**

To help us meet all your healthcare needs, please fill out this form completely in ink.  
If you have any questions or need assistance, please ask us and we will be happy to help.

**Patient Information (Confidential)**

Name \_\_\_\_\_ Date \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
Email \_\_\_\_\_

Check Appropriate Box:     Minor     Single     Married     Separated     Divorced     Widowed

If Student, Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Full or Part Time? \_\_\_\_\_  
Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse; Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Wk Phone \_\_\_\_\_  
Person to contact in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Is this person currently a Patient in our office? \_\_\_\_\_

**For your convenience, we offer the following methods of payment. Please check the option you prefer.**

Cash     Check     Credit Card     I wish to discuss the office's payment policy

**Insurance Information**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your Deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_

**Do you have any additional Insurance?**     Yes     No    **If Yes, complete the following**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your Deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_