PATIENT INFORMATION

Thank you for choosing our office. In order to serve you better, we need the following information. Please print. All information will be confidential.

Date______________ Patient Name______________________________ Nickname______________________________

Physical Address_________________________________ City_____________________ State_____ Zip_____________

Mailing Address(If different)_________________________ City___________________ State______ Zip_____________

Home Phone #____________ Daytime Phone#___________ Cell Phone #___________ E-Mail Address_____________

Birth Date____________________ SSN_________________________ Male_____ Female_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Other

Patient's or Parent's employer___________________________ Employer's phone # ________________________

Business address__________________________________ City________________ State_____ Zip_______________

Spouse / Parent's name_____________________________ Employer____

Person to contact in case of emergency________________________________ Phone #______________________

Relationship to patient__________________________

Primary Insured:

Name__________________________________ Relationship to patient _______________________________________

Birth date________________ SSN__________________________ Driver's License #____________________________

Employer___________________________________ Employer's phone #_________________________________

Responsible Party

Name of person responsible for account___________________________ Relationship to patient____________________

Phone #___________________ Address_______________________________ City_______________ State______

Driver's License #_______________________ SSN__________________________ Birth date_____________________

Employer________________________ Employer's phone #_________________

AUTHORIZATION AND RELEASE

I authorize the release of any information concerning mine or my child's health care, advise, and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize the payment of insurance benefits otherwise payable to me directly to the doctor.

____ Date ______________________________

Signature of patient or parent/Legal guardian (if minor)