PATIENT INFORMATION

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

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX

Date: _____

Patient Name: _____ (First) _____ (MI) _____ (Last)

SSN: _____ ❑ Male ❑ Female Birthdate: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or parent's employer: _____ Work phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

Spouse or parent's name: _____ Employer: _____ Work phone: _____

If patient is a student, name of school/college: _____ City: _____ State: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home phone: _____

Driver's license #: _____ Birthdate: _____ Financial institution: _____

Employer: _____ Work phone: _____

Is this person currently a patient at our office? ❑ Yes ❑ No

Insurance Information

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security Number: _____ Date employed: _____

Name of employer: _____ Work phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Insurance company: _____ Group #: _____ Union or local #: _____

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: _____ Social Security Number: _____ Date employed: _____

Name of employer: _____ Work phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Insurance company: _____ Group #: _____ Union or local #: _____

Ins. Co. address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

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

X _____ _____

Signature of patient or parent if minor — Date

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