

## 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 Name (Last): \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Circle Appropriate: Minor Single Married Divorced Widowed Separated  
Occupation: \_\_\_\_\_ Employment: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_ Local#: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
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: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

### INSURANCE INFORMATION

Insured is: \_\_\_ Patient \_\_\_ Third Party  
Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date employed: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_  
Address of Employer: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_

I authorize release of any information concerning my health care, advice or 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.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date