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.

Date ______________________

Patient name ______________________ (FIRST / MI / LAST) Patient # ______________________

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 in 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 # ______________

Insurance 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 # ______________

Insurance co. address ______________________ City ______________ State ________ Zip ________

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

AUTHORIZATION & RELEASE

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