

**PATIENT INFORMATION**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

\*\*\*If an email address is provided, you will be reminded via email for scheduling annual and semiannual appointments.

How did you hear about our office? \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY (if different from patient)**

Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_  
Area Code Area Code City State Zip

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**(ONLY if there is NO ins. card available )**

**INSURANCE INFORMATION**

**Primary**  
Insurance \_\_\_\_\_

Ins. Address \_\_\_\_\_

Name of insured \_\_\_\_\_

Insured's ID# \_\_\_\_\_

Group# \_\_\_\_\_

Relationship of patient to the insured \_\_\_\_\_

**Secondary**  
Insurance \_\_\_\_\_

Ins. Address \_\_\_\_\_

Name of insured \_\_\_\_\_

Insured's ID# \_\_\_\_\_

Group# \_\_\_\_\_

Relationship of patient to the insured \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Would you like your medical records sent to your primary physician? YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_  
**Date**