



# Welcome

## Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

### Patient Information (Confidential)

Patient Number \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_ Marital Status    Single    Married    Separated    Divorced    Widowed  
State/Prov. \_\_\_\_\_  Full Time     Part Time

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

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 \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN# \_\_\_\_\_

Is this Person Currently a Patient in our Office?     Yes     No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash     Personal Check    Credit Card     VISA     MasterCard     I wish to discuss the office's payment policy

### Insurance information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_

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 # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Over Please