

Patient Information

TODAY'S DATE: _____

Patient Information

NAME: _____

AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____

SEX: _____ MARITAL STATUS: _____

CITY: _____ STATE _____ ZIP _____

email: _____

DID YOU SEE OUR WEBSITE Yes No

SOCIAL SEC #: _____

ARE WE IN YOUR PLAN DIRECTORY? Yes No

DRIVERS LICENSE # _____ State _____

EMPLOYER: _____

PERMANENT ADDRESS: _____

ADDRESS: _____

CITY/ST/ZIP: _____

CITY/ST/ZIP: _____

HOME PHONE #: _____

PHONE #: _____

WORK PHONE #: _____

MOBILE PHONE#: _____

Responsible Party Information

NAME: _____

RELATION TO PATIENT: _____

ADDRESS: _____

EMPLOYER: _____

CITY/ST/ZIP: _____

ADDRESS: _____

HOME PHONE: _____

CITY/ST/ZIP: _____

SOCIAL SECURITY #: _____

WORK PHONE: _____

Primary Insurance (Please give your insurance card(s) to the receptionist)

INSURANCE CO.: _____

POLICYHOLDER'S NAME: _____

ADDRESS: _____

POLICYHOLDER SSN: _____

CITY/ST/ZIP: _____

POLICYHOLDER D.O.B: _____

PHONE # _____

POLICY #: _____

Effective dates: _____ through _____

GROUP #: _____

PLAN NAME _____ COPAY \$ _____

RELATION TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

Additional / Secondary Insurance

INSURANCE CO.: _____

POLICYHOLDER'S NAME: _____

ADDRESS: _____

POLICYHOLDER SSN: _____

CITY/ST/ZIP: _____

POLICYHOLDER D.O.B: _____

PHONE # _____

POLICY #: _____

Effective dates: _____ through _____

GROUP #: _____

PLAN NAME _____ COPAY \$ _____

RELATION TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

Miscellaneous

In case of emergency, notify _____

Relation to patient _____

Home phone _____

Work phone _____

Signature

The undersigned verifies that the above information is true and correct.

Signature: _____

Date: _____

(If patient is a minor - signature of parent/guardian)

Patient Communication Authorization

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

- It's okay to call my home phone number. Okay to leave a message? yes no
- It's okay to call my mobile phone number. Okay to leave a message? yes no
- It's okay to call my work phone number Okay to leave a message? yes no
- Call only this number. _____ Okay to leave a message? yes no
- Do not speak to family members

I give permission to the individual(s) listed below to receive protected health information:

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature _____

Date _____