

# Patient Information

TODAY'S DATE: \_\_\_\_\_

## Patient Information

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/ST/ZIP: \_\_\_\_\_  
PHONE #: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
SEX: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
DRIVERS LICENSE # \_\_\_\_\_ State \_\_\_\_\_  
PERMANENT ADDRESS: \_\_\_\_\_  
CITY/ST/ZIP: \_\_\_\_\_  
HOME PHONE #: \_\_\_\_\_  
WORK PHONE #: \_\_\_\_\_  
REFERRED BY WHOM \_\_\_\_\_

## Responsible Party Information

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/ST/ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/ST/ZIP: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_

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

INSURANCE CO.: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/ST/ZIP: \_\_\_\_\_  
PHONE # \_\_\_\_\_  
Effective dates: \_\_\_\_\_ through \_\_\_\_\_  
PLAN NAME \_\_\_\_\_ COPAY \$ \_\_\_\_\_

POLICYHOLDER'S NAME: \_\_\_\_\_  
POLICYHOLDER SSN: \_\_\_\_\_  
POLICYHOLDER D.O.B: \_\_\_\_\_  
POLICY #: \_\_\_\_\_  
GROUP #: \_\_\_\_\_  
RELATION TO PATIENT: \_\_\_\_\_  
POLICYHOLDER'S EMPLOYER: \_\_\_\_\_

## Additional / Secondary Insurance

INSURANCE CO.: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/ST/ZIP: \_\_\_\_\_  
PHONE # \_\_\_\_\_  
Effective dates: \_\_\_\_\_ through \_\_\_\_\_  
PLAN NAME \_\_\_\_\_ COPAY \$ \_\_\_\_\_

POLICYHOLDER'S NAME: \_\_\_\_\_  
POLICYHOLDER SSN: \_\_\_\_\_  
POLICYHOLDER D.O.B: \_\_\_\_\_  
POLICY #: \_\_\_\_\_  
GROUP #: \_\_\_\_\_  
RELATION TO PATIENT: \_\_\_\_\_  
POLICYHOLDER'S EMPLOYER: \_\_\_\_\_

## Miscellaneous

In case of emergency, notify \_\_\_\_\_  
Home phone \_\_\_\_\_

Relation to patient \_\_\_\_\_  
Work phone \_\_\_\_\_

## Signature

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

Signature: \_\_\_\_\_  
(If patient is a minor - signature of parent/guardian)

Date: \_\_\_\_\_