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_____ Patient # _____
FIRST MI LAST

SSN_____ ☐ Male ☐ Female Birth Date _____ 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 you for referring you? _____

Person to contact in case of emergency Phone _____

In case of a medical emergency, if the patient is of school age 15 +, it is all right to treat in my absence.

X _____ _____

Parent or guardian signature Date

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone_____

Driver's License #_____ Birth Date_____ Financial institution _____

Employer _____ Work phone_____

Is this person currently a patient at our office? ☐Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birth Date _____ SSN _____ Date employed_____

Name of Employer _____Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. 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 _____

Birth Date _____ SSN _____ Date employed_____

Name of Employer _____Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

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

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