PATIENT INFORMATION
(PLEASE PRINT)

NAME_____ **Birthdate:** _____
Last **First** **MI**

Sex: M F **Marital Status: S M W D** **Home Phone Number (____)**_____

Cell Number (____) _____

RACE:_____ **Ethnicity:**_____ **Language:**_____

Address: _____**City:**_____ **State** _____ **Zip Code**_____

Social Security No: _____ **Employer:** _____**Work Phone: (_____)**_____

E-mail address: _____

Spouse Name: _____ **Employer:** _____ **Work Phone: (____)**_____

Spouse Social Security No: _____ **Is spouse a current patient at this office? Y N**

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ Birth date:_____ SS No: _____

Relationship to patient: Self Spouse Child Parent Other

Insured's Employer: _____

Insurance Company: _____ Effective Date of Coverage: _____

SECONDARY INSURANCE

Name of Insured: _____ Birth date: _____ SS No._____

Relationship to patient: Self Spouse Child Parent Other

Insured's Employer: _____

Insurance Company: _____ Effective date of Coverage: _____

Dependent Children Information

Name	**Date of Birth**	**CIRCLE ONE**
_____	_____	M F
_____	_____	M F
_____	_____	M F
_____	_____	M F

Please list someone we can contact in case of an **emergency** **who doesn't live in your household.**

Name_____**Phone No:** _____**Relationship** _____

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Who referred you to our office? _____

I wish to be contacted in the following manner (check all that apply and initial on line):

_____ **Home Telephone** _____
_____ **OK to leave message on machine with detailed information**
_____ **OK to identify office with call-back number only**
_____ **Leave message with call-back number only**
_____ **Leave message with family member**
_____ **Other**_____
_____ **Written Communications**
_____ **OK to mail to my home address**

_____ **Work Telephone** _____
_____ **O.K. to leave message on machine with detailed information**

_____ **Other** _____

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Patient Signature ______________________________ **Date:** ____________________