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 <u>who doesn't live in your household</u>.**

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** _____ _____ **Work 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**
_____ **Written Communications**
_____ **OK to mail to my home address**
_____ Other_____

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Patient Signature _____ **Date:** _____