Patient Information Form

Name ____Date ________________
First Middle Last

Address ____

City ________________________State _________ Zip __________

Cell # ________________ Home phone _________________

Soc. Security # __________________Birthdate __________________

Email ____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school ______________________________________

City _________________ State _________

Patient or parent's employer ____

Work phone _________________________

Business address ____

City ________________________ State _________ Zip _________________

Spouse or parent's name ________________Employer _________________________________

Work phone _________________________

Whom may we thank for referring you ____

Responsible Party

(If different from patient)

Name of person responsible for this account _________________ Relationship to patient __________________

Address ____

Home phone ________________________

Driver's license # ______________________Birth Date _____________ Soc. Security # ________________

Employer ____

Work phone _________________________

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

(Please show your Insurance Policy Card to our front desk OR fill out the following form)

Name of insured ____________________

Relationship to patient ____________________

Birthdate __________ Soc. Security # __________ Date employed __________

Name of employer ____________________ Union or local # __________

Work phone ____________________

Employer address ____________________

City __________ State __________ Zip __________

Insurance Co. ____________________

Tel. # __________ Grp. # __________ Policy/I.D.# __________

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 ____________________

Soc. Security # __________ Date employed __________

Name of employer ____________________ Union or local # __________

Work phone ____________________

Employer address ____________________

City __________ State __________ Zip __________

Insurance Co. ____________________

Tel. # __________ Grp. # __________ Policy/I.D.# __________

Ins. Co. address ____________________

City __________ State. __________ Zip __________

How much is your deductible __________ How much have you used __________ Max annual benefit __________

X ____________________

Signature of patient (or parent, if minor)