PATIENT INFORMATION

NAME _____ BIRTH DATE _____
First Middle Last

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ SOCIAL SECURITY # _____

CELL PHONE _____ OCCUPATION _____ MARITAL STATUS _____

WHY ARE YOU HERE TO SEE THE DOCTOR? _____

IF YOU ARE A MINOR: GUARDIAN NAME _____ PHONE _____

NAME OF REFFERING PARTY _____

INSURANCE INFORMATION

PRIMARY CARE PHYSICIAN _____ PHONE _____ LAST VISIT DATE _____

PRIMARY INSURANCE _____ INSURANCE PHONE _____

CONTRACT/ID # _____ GROUP # _____

INSURED PARTY _____ RELATIONSHIP _____ BIRTH DATE _____

SOCIAL SECURITY # _____ EMPLOYER: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____ INSURANCE PHONE _____

INSURED PARTY _____ BIRTH DATE _____ CONTRACT/ID # _____ GROUP # _____

SOCIAL SECURITY # _____ EMPLOYER: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

FINANCIAL RESPONSIBILITY

My signature verifies that I have received a copy of the office financial policies and I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 30 days past due, delinquency at the lesser of the annual rate of 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. The information given today is accurate and true to the best of my knowledge. Please sign and date the initial visit signature line.

Patient Signature – Initial Visit	Date	Witness
Patient Signature - Updated	Date	Witness
Patient Signature - Updated	Date	Witness

FOR OFFICE USE ONLY: PT NO. _____ INITIALS _____