WELCOME

We are pleased to welcome you and your family to our practice. Please take a few minutes to fill out information in this form. We take pride in our work, and looking forward to serve you the best we could.

PATIENT INFORMATION

Date_____/_____/_____

Patient name_____
FIRST NAME INITIAL LAST NAME PREFERRED NAME

Sex M___F___ Age_____Birthday____/____/_____ Single ☐_ Married ☐ Divorced ☐ Separated ☐ Widow ☐

Home address _____City_____State___Zip_____

Billing address (if different)_____

Home telephone_____Work_____Cell_____ Alternative_____

Driver license#_____ SS#_____

Patient employed by_____Occupation_____

Parent/Guardian's Name (if pt is a minor)_____

How did you hear from us: Friend _____Web_____Phone book_____

Other _____

In case of emergency who should be notified? _____Phone_____

Your e-mail address_____

Would you like to receive email correspondence: ___Yes ___No

PRIMARY INSURANCE

Person responsible for account if different than above_____
FIRST NAME INITIAL LAST NAME

Relation to patient _____ Birthday_____ SS#_____

Address _____City_____State____Zip_____

Home telephone _____Work_____Cell_____

Person responsible employed by_____Occupation_____

Business address_____

Insurance company_____Phone_____

Contract#_____Group#_____ Subscriber#_____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes ☐ No ☐

Insurance company_____Phone_____

Subscriber Name/Birthday/#_____Group#_____