Welcome to Our Practice

Please fill out forms in black ink.
Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____ Home Phone _____ Cell Phone _____

PATIENT INFORMATION

Name _____ SS# _____
Last First MI

Address _____ email _____

City_____ State _____ Zip _____

Sex ____ M ____ F ____ Age _____ Birthdate _____

Minor ____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Patient Employer / School _____ Occupation _____

Employer / School Address _____ Work Phone# _____

Referring Doctor _____ Phone#_____

In case of emergency, who should be notified? _____ Phone# _____

PRIMARY INSURANCE

Subscriber Name _____ Relationship to patient _____
Last Name First Name MI

Birthdate _____ Soc. Sec# _____

Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

Bus. Address _____ Bus. Phone _____

Insurance Company _____ Address _____

ID# _____ Group# _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____ Yes _____ No

Subscriber Name _____ Relationship to patient _____

Birthdate _____ Soc. Sec# _____

Address _____ City _____ State _____ Zip _____
If different from patient

Employed by _____

Insurance Company _____

ID# _____ Group# _____

ASSIGNMENT AND RELEASE

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____
Signature of patient or parent/guardian if minor Date