Patient Information

Name:		
Parent's Name (if a minor):		
Marital Status:	Spouse's Name:	
Complete Street Address:		
City, State, Zip Code:		
Date of Birth:	Age Today:	SSN:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		

How did you choose our services? ( ) Website ( ) Location ( ) Family/Friend ( ) Hours
( ) Other ____

Insurance Information

Policyholder's Name:	
Relationship to Patient:	
Patient's SSN:	
Patient's Date of Birth:	
Insurance Company:	
Insurance ID Number:	
Group Number:	
Office Co-Pay:	**Your co-pay is due at the time of your appointment.*
Insurance Company Address:	
Policy Holder's Employer:	

Do you have secondary insurance? ( ) No ( ) Yes If yes, please complete the following.

Policyholder's Name:
Relationship to Patient:
Patient's SSN:
Patient's Date of Birth:
Insurance Company:
Insurance ID Number:
Group Number:
Insurance Company Address:
Policy Holder's Employer:

Emergency Contact Information

Emergency Contact Name:
Phone:
Relationship to Patient:

I certify the above information is true and correct, and I agree to full financial responsibility of all charges for services rendered, regardless of insurance coverage. Past due accounts may be submitted to a collections process.

Signature (parent's signature if a minor):___________________________________ Date:________