PATIENT INFORMATION

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_____Patient name_____
First MI Last

SS#_____ __ Male __Female Birthdate_____

Home Phone_____ Cell Phone _____ Email_____

Address_____City_____State_____Zip_____
Check appropriate box __ Minor __Single __Married __Divorced __Widowed __Separated

Patient's employer_____ Work phone _____

Parent/guardian name_____Daytime phone_____

Full time student? ___ yes Part time student? ___ yes School _____

Person to contact in case of emergency_____Phone_____

_____

Patient or Parent/Guardian signature **Date**

INSURANCE INFORMATION

Name of insured_____ Relationship_____

Birthdate_____ SS #_____

Insurance Company_____ ID #_____

2nd Insurance Company_____ ID# _____

I authorize release of any 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.

Signature of patient or parent/guardian **Date**