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 __________

MEMBER 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 7%, 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 __________