

*Patient Demographics*

**PATIENT INFORMATION**

Patient's Legal Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_

Gender: M / F Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Patient Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If Patient is a minor, please complete the next section, otherwise skip to Insurance Information

MOTHER

FATHER

\_\_\_\_\_ Name \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ Home # \_\_\_\_\_

\_\_\_\_\_ Work # \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_ Employer \_\_\_\_\_

\_\_\_\_\_ Driver's License # \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company: \_\_\_\_\_ Policyholder's name: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Policyholder's Employer: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Policyholder's name: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Policyholder's Employer: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Is it O.K. to leave message with detailed information on any of the above phone numbers? YES or NO

Would you prefer us to leave a message with a call-back number only? YES or NO

Emergency Contact/Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

**We ask that your copayment, deductible and/or coinsurance for services provided be paid today. If you need to discuss a payment plan, please ask to speak to our Collections Office before seeing the doctor.**

\_\_\_\_\_  
(Signature of Patient/Patient Guardian)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_\_  
(Date)