

**PATIENT INFORMATION (CONFIDENTIAL)**

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

EMAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV \_\_\_\_\_

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
STATE / PROV. ZIP / P.C.

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

SPOUSE OR PARENT'S/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DRIVER'S LICENSE# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SSN/SIN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
STATE / PROV. ZIP / P.C.

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D # \_\_\_\_\_  
STATE / PROV. ZIP / P.C.

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
STATE / PROV. ZIP / P.C.

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D # \_\_\_\_\_  
STATE / PROV. ZIP / P.C.

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

X \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER \_\_\_\_\_