

Welcome

Thank you for selecting us.

Patient Information (Confidential)

Name _____ Preferred Name _____
SS# / SIN _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
If Student, Name of School/College _____ State _____ Part Time Full Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible from this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ SS# / SIN _____
Employer _____ Work Phone _____

For your convenience, we offer the following methods of payment. Payment in full at each appointment is required.

Cash Personal Check Credit Card VISA MasterCard Discover/AMEX I wish to discuss the office policy

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# / SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip Code _____
Insurance Company _____ Group # _____ Policy/ ID# _____
Ins. Co. Address _____ Phone # _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# / SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip Code _____
Insurance Company _____ Group # _____ Policy/ ID# _____
Ins. Co. Address _____ Phone # _____