



# Patient Information

TODAY'S DATE \_\_\_\_\_

LAST NAME _____	FIRST NAME _____	M.I. _____
ADDRESS _____		
CITY _____	STATE _____	ZIP CODE _____
HOME PHONE (____) _____	CELL/DAY TIME PHONE (____) _____	
E-MAIL _____		ALTERNATIVE E-MAIL _____
MALE/FEMALE _____	DATE OF BIRTH _____	SS # _____ DRIVER LI.# _____
MARITAL STATUS:	SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____	
SPOUSE'S NAME _____		

## PATIENT EMPLOYMENT INFORMATION

EMPLOYER'S NAME _____	WORK PHONE (____) _____	Ext: _____
REFERRED TO OUR OFFICE BY _____		

## PERSON RESPONSIBLE FOR ACCOUNT (if different from patient information):

LAST NAME _____	FIRST NAME _____	M.I. _____
ADDRESS _____		
CITY _____	STATE _____	ZIP CODE _____
HOME PHONE (____) _____	CELL/DAY TIME PHONE (____) _____	
E-MAIL _____		ALTERNATIVE E-MAIL _____
MALE/FEMALE _____	DATE OF BIRTH _____	SS# _____ DRIVER LI. # _____
EMPLOYED BY: _____	WORK PHONE# (____) _____	
RELATIONSHIP TO PATIENT SELF _____	SPOUSE _____	PARENT _____ OTHER _____

## INSURANCE INFORMATION OR PAYMENT INFORMATION

Are you a self-pay patient? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY INSURANCE: _____	POLICY #: _____ GROUP #: _____
MEDICAID/CHIP #: _____	
Whom can we thank for your visit? _____	
How did you locate us or get our number: <input type="checkbox"/> Phonebook <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper <input type="checkbox"/> TV Advertisement	