Welcome to our office! We are honored you have placed your confidence in us to take care of you and/or your family. To assist us serving you, please complete the following forms. If there are ever any changes in your health, please inform us. Personal & Contact Information all information is kept strictly confidential

PATIENT'S INFORMATION

Full Name _____ Birthdate_____

Home Address _____

To confirm appointments: Cell#_____ Email address _____

RESPONSIBLE PARTY

FULL NAME _____ Birthdate_____

Marital Status: ▫ Single ▫ Married ▫ Widow ▫ Divorced ▫ Separated SSN: _____

Home Address _____

Driver's License#: _____ Cell#_____ Home#_____

Email Address _____

Insurance Information: Primary Insurance

Subscriber Name: _____ SSN: _____

Birthdate _____ Employer: _____

Insurance Company: _____ Insurance Phone Number: _____

Group Number: _____ ID Number (may be SSN): _____

Secondary Insurance

Subscriber Name: _____ SSN: _____

Birthdate _____ Employer: _____

Insurance Company: _____ Insurance Phone Number: _____

Group Number: _____ ID Number (may be SSN): _____

In case of an emergency who should we contact: Name _____

Phone# _____ Relationship to patient: _____

How Did You Hear About Us? ▫ Friend or family member: _____

▫ Insurance ▫ Google ▫ Yellow Pages ▫ TV ▫ Online search ▫ Facebook ▫ Radio

▫ Instagram ▫ Other: _____

The information provided on this form is correct to the best of my knowledge.

_____

Parent/Guardian's name Signature Date