Patient Information

Date_____ Patient Name_____ Birth Date_____

☐ Male ☐ Female SSN _____ ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address_____ City_____ State_____

Zip Code_____ Home Phone_____ Cell Phone_____

Email_____ Employer_____

Preferred method of contact (check all that apply): ☐ Email ☐ Phone ☐ Text

Name of school/college, if applicable_____ City_____ State_____

Emergency contact name_____ Phone_____

In case of a medical emergency, if a patient is of school age 15+, it is all right to treat in my absence.

_____ _____

Parent or guardian signature Date

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Address (if different from above)_____ Phone_____

Email_____ Employer_____

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Insurance holder_____ Relationship to patient_____

Birth Date_____ SSN_____ Date employed_____

Name of employer_____ Insurance company_____

Insurance company address_____ City_____ State_____

Group number_____ Subscriber ID number_____ Deductible_____

Have you used this insurance before? YES NO

Secondary Insurance

Insurance holder_____ Relationship to patient_____

Birth Date_____ SSN_____ Date employed_____

Name of employer_____ Insurance company_____

Insurance company address_____ City_____ State_____

Group number_____ Subscriber ID number_____ Deductible_____

Have you used this insurance before? YES NO

I authorize release of any information concerning my or my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of patient or parent/guardian if minor Date