CONFIDENTIAL PATIENT INFORMATION

Name _____ Email _____

Address _____ City_____ State _____ Zip _____

Date of Birth ____/____/_____ Soc. Sec. # _____ Driver's Lic. # _____

Sex: M ___ F ___ Home Phone (____) ____-_____ Cell Phone (____) ____-_____ Work Phone (____) ____-_____

Employer _____ Occupation _____

Full Time Student? _____ Where? _____

Emergency Contact _____ Phone (____) ____-_____ Relation _____

Nearest relative not living with you _____ Phone (____) ____-_____ Relation _____

Nearest friend not living with you _____ Phone (____) ____-_____ Relation _____

Reason for today's visit _____

How did you hear about us? ◯ Google Reviews ◯ Insurance Provider's List ◯ Facebook ◯ Drive-by or Walk-in

Referred By _____ Other _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Relation, if other than the patient _____ Phone (____) ____-_____

Address _____ City_____ State _____ Zip _____

INSURANCE INFORMATION

Please complete the following section **only** if we are to file insurance for you.

Insurance Company _____

Claim/Billing Address _____

Who is the policy holder? _____ Relation _____

Policy Holder's Address _____ Date of Birth ____/____/_____

Soc. Sec. # _____ Ins. ID # _____ Phone (____) ____-_____

Employer _____ Insurance Group or Plan # _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify that this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature _____ Date _____