Welcome
Thank you for selecting our practice!

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ____________________ ☐ Male ☐ Female
SS#____________________ Birth date ____________
Address ____________________ City ____________ State________ Zip__________
Home Phone ____________ Work Phone____________ Cell Phone____________
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Patient 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 an emergency____________________
Email Address____________________

Responsible Party/Insurance Information

Responsible Party/Policy Holder’s name____________________
Relationship to patient____________________
Address ____________________ City ____________ State________ Zip__________
Home Phone ____________ Work Phone____________ Cell Phone____________
Employer____________ Birth date____________ SS#____________
Employer Address____________ City____________ State________ Zip__________
Insurance Company____________ Group #____________ Policy/ID #____________
Ins. Co. Address____________ City____________ State________ Zip__________

Do you have additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Policy Holder’s name____________________
Relationship to patient____________________
Address ____________________ City ____________ State________ Zip__________
Home Phone ____________ Work Phone____________ Cell Phone____________
Employer____________ Birth date____________ SS#____________
Employer Address____________ City____________ State________ Zip__________
Insurance Company____________ Group #____________ Policy/ID #____________
Ins. Co. Address____________ City____________ State________ Zip__________

I understand that the total fee charged is my obligation. Once my insurance has paid, any difference is due and payable by me. If my insurance carrier has not paid within 60 days following a claim, the entire balance is subject to 1.5% APR finance charges, due and payable by me. I also understand that 48 hours notice is required for any changes in scheduling.

Patient Signature____________________