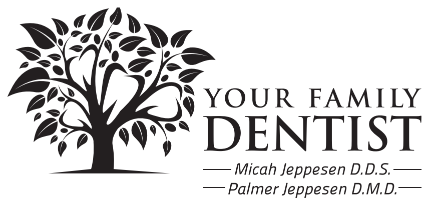

Welcome
Thank you for selecting our practice!

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 ____________________ Cell Phone____________________ Text Messages: ☐ Yes ☐ No
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____________________