Legal Name: _____

Nickname: _____Date of Birth: ____/____/_____SSN:_____ Male___ Female___

Physical Address_____

Billing address (if different from above)_____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____ May we send information here? Yes_____ No _____

Name of Parent (if patient is a minor) or spouse: _____

SSN: _____ Home phone: _____ Cell: _____ Work: _____

In Case of an Emergency, Contact: _____Relationship:_____

Home phone: _____ Cell: _____ Work: _____

Can we leave a detailed message on any of the above phone numbers? Yes _____ No _____

A copy of your insurance card is required: please present your card to the receptionist. If you do not present your card, you may be responsible for full payment at time of service.

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ DOB: _____/_____/_____ SSN: _____

Relationship to Patient: _____ Employer: _____

Do You Have Secondary Insurance? Yes _____ No _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ DOB: _____/_____/_____ SSN: _____

Relationship to Patient: _____ Employer: _____

Complete this section only if someone <u>other than the patient</u> is financially responsible

Responsible Party: _____ Relationship to Patient: _____

DOB: ____/_____/_____ SSN: _____ Employer: _____

Home Address, City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____