Date ___________________ A B C

Confidential Patient Information

Patient's Name ____
Last First Middle
Preferred Name ___________________________________
Address ____
Street City State Zip
Home Phone _________________________ Work Phone _________________________ Cell Phone _____________________
Birth date __________________________ Social Security # _________________
Drivers License Number ______________________ Email__________________________________
If Patient is a minor, give parent's or guardian's name ____
Whom may we thank for referring you to our office? ____

Confidential Responsible Party Information

Name ____ Martial Status _______________
Last First Middle

Residence ____
Street City State Zip
Mailing Address ____
Street City State Zip
How long at this address _________________ Home Phone _____________________Work Phone _____________________
Cell Phone ______________________________________
Previous Address (if less than 3 years) ____
Street City State Zip
Social Security # _________________________ Birth date ____________________ Relationship to Patient ______________
Drivers License Number ____________________
Employer _____________________________ Occupation ________________________ # Years Employed _______________
Spouse's Name ____ Relationship to Patient _____________
Last First Middle
Spouse's Employer ________________________ Occupation _____________________ # Years Employed ______________
Spouse's Social Security # ___________________ Birth date ______________________ Work phone ___________________

Insurance Information

Policy Holder's Name ____ & Soc. Sec. # _______________________
Last First Middle
Insurance Company ________________________________Group # ____________________Union Local # _______________
Insurance Co. Address ____Ins. Co. Ph. _________________
Street City State Zip
Policy Holder's Employer ____
Do you have dual coverage? No _____ Yes _____ If yes:
Policy Holder's Name ____ & Soc. Sec. # _________________
Insurance Company _________________________________ Group # __________________ Union Local # _______________
Insurance Co. Address ____Ins. Co. Ph. ________________
Policy Holder's Employer ____

Emergency Information

Name of nearest relative not living with you ____
Complete Address ____
Street City State Zip
Phone ____ Relationship ____
I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parent's signature if minor)
____
Updates (date & initial) ____
CONFIDENTIAL (for record and pretreatment evaluation)