

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 ADDRESS _____

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. # _____
Last First Middle

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Ins. Co. Ph. _____
Street City State Zip

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____
Street City State Zip

Phone _____ Relationship _____
Street City State Zip

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)