Patient Information (Confidential)

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Phone #: Home: _____ Cell: _____ Work: _____

Employer: _____

Would you like confirmation by Email_____ or Text_____

Email Address: _____

Date of Birth: Day: _____ Month: _____ Year: _____ Age: _____ Sex: ☐ M ☐ F

Marital Status: _____ Is any immediate family a patient in this office: ☐ Yes ☐ No

How did you hear about our office? ☐ Phonebook ☐ Website ☐ Other _____

Whom may we thank for referring you? _____

Spouse or Parent's Name: _____

Person to contact in case of emergency: _____ Phone: _____

Insurance Information:

Insurance Company: _____

Name of Insured: _____ Name of Policy holder/Employer: _____

Policy or Group #: _____ Certificate/I.D. #: _____ Date of Birth: _____

Student: Name of School: _____ Student I.D. #: _____

Plan Maximum: _____ Coverage Year End: _____

Do you have a Secondary Insurance Policy:

Insurance Company: _____

Name of Insured: _____ Name of Policyholder/Employer: _____

Policy or Group #: _____ Certificate/I.D. #: _____ Date of Birth: _____

Plan Maximum: _____ Coverage Year End: _____

Signature of Patient or Parent if Minor: _____