Print Form

WELCOME TO OUR OFFICE

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Today's Date _____

Thank you for choosing our office.
In order to serve you properly, we will need the following information. (Please print.) All information will be strictly confidential.

PATIENT INFORMATION:

Name _____ Date of Birth _____ Age _____ Sex ___
Title First M.I. Last

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Social Security No. _____

Daytime Phone _____ Marital Status □ single □ married □ widowed □ divorced

Cell Phone _____ Name of Employer _____

Fax Number _____ Occupation _____

Email Address _____ Employer Address _____

If child, parent's or guardian's name _____ Relationship _____

If married, spouse's name, _____ Spouse DOB _____ Spouse SSN_____

Person financially responsible for this account _____

INSURANCE INFORMATION:

Primary Medical Insurance:

Insurance Name _____ Policyholder's Name _____

Insured ID Number _____ Policyholder's DOB _____

Policy Group No _____ Plan Name _____

Secondary Insurance (if applicable) or Vision Insurance:

Insurance Name _____ Policyholder's Name _____

Insured ID Number _____ Policyholder's DOB _____

Policy Group No _____ Plan Name _____

Nearest relative or friend not residing with you _____ Relationship _____

Phone Number _____

How did you hear of us? □ phone book □ insurance list □ internet □ friend/family (whom _____)

□ physician office (Dr. _____) □ Other (_____)

What is your chief complaint?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the "NOTICE OF PRIVACY PRACTICES" document.

Patient, Parent or Guardian Signature _____ Date _____