# PATIENT INFORMATION


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## PERSONAL INFORMATION

| | | |
|---|---|---|
| NAME | BIRTHDATE | SS# / SIN |
| ADDRESS | CITY | STATE / ZIP |
| PHONE | EMAIL ADDRESS | |
| CHECK APPROPRIATE BOX ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED | | |
| STUDENTS - NAME OF SCHOOL/ COLLEGE | CITY/STATE | FULL TIME ☐ PART TIME ☐ |
| EMPLOYER (PATIENT OR PARENT/ GUARDIAN'S) | | |
| EMPLOYERS ADDRESS | CITY/STATE/ZIP | WORK PHONE |
| SPOUSE OR PARENT/GUARDIAN'S NAME | EMPLOYER | WORK PHONE |
| WHOM MAY WE THANK FOR REFERRING YOU? | | |

## RESPONSIBLE PARTY

| | | |
|---|---|---|
| NAME OF PERSON RESPONSIBLE | | RELATIONSHIP TO PATIENT |
| ADDRESS | CITY | STATE / ZIP |
| PHONE | EMAIL ADDRESS | |
| DRIVER'S LICENSE # | STATE | BIRTHDATE |
| FINANCIAL INSTITUTION | CITY/STATE | SS# / SIN |
| EMPLOYER | CITY/STATE/ZIP | WORK PHONE |
| IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE? ☐ YES ☐ NO | | |
| FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT: ☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX | | PAYMENT IS REQUIRED IN FULL AT EACH APPOINTMENT. |

## INSURANCE

| | | | |
|---|---|---|---|
| NAME OF INSURED | | RELATIONSHIP TO PATIENT | |
| BIRTHDATE | SS# / SIN | NAME OF EMPLOYER | UNION OR LOCAL # |
| EMPLOYER ADDRESS | | CITY/STATE | WORK PHONE |
| INSURANCE COMPANY | | GROUP # | POLICY I.D.# |
| INSURANCE COMPANY ADDRESS | | CITY/STATE/ZIP | |
| HOW MUCH IS YOUR DEDUCTIBLE? | | HOW MUCH HAVE YOU USED? | MAX. ANNUAL BENEFIT |
| DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO | | IF YES, COMPLETE THE FOLLOWING | |
| NAME OF INSURED | | RELATIONSHIP TO PATIENT | |
| BIRTHDATE | SS# / SIN | NAME OF EMPLOYER | UNION OR LOCAL # |
| EMPLOYER ADDRESS | | CITY/STATE | WORK PHONE |
| INSURANCE COMPANY | | GROUP # | POLICY I.D.# |
| INSURANCE COMPANY ADDRESS | | CITY/STATE/ZIP | |
| HOW MUCH IS YOUR DEDUCTIBLE? | | HOW MUCH HAVE YOU USED? | MAX. ANNUAL BENEFIT |