

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
 CHECK APPROPRIATE BOX:  CHILD  SINGLE  MARRIED  
 PATIENT'S EMPLOYER \_\_\_\_\_ WORK NUMBER \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
 PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF RESPONSIBLE PARTIES FOR THIS ACCOUNT \_\_\_\_\_  
 PATIENT OR PARENT/GUARDIAN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OTHER/CELL \_\_\_\_\_  
 SSN# \_\_\_\_\_ D.L. # \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO  
 SPOUSE OR OTHER PARENT/GUARDIAN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OTHER/CELL \_\_\_\_\_  
 SSN# \_\_\_\_\_ D.L. # \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
 NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
 INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
 NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
 INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

FORM 154735 8/01/05 ITEM 8101

X  
SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NUMBER