Patient Information

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You can complete this form by tabbing through the fields in Microsoft Word, or by printing out the form and hand-writing your information. If you have a question while completing the form in Word, simply hover over the field in question and press the F1 key on your keyboard for pop-up assistance.

Name: _____ Date: _____ Gender: ☐ Male ☐ Female

Address: _____

Home Phone: _____ Work Phone: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Occupation: _____

Employer Name & Address: _____

Where should statements of your account be sent if different from above?

_____

Emergency Contact:
Name: _____ Phone Number: _____

Who referred you to our office? _____

Primary care physician _____ Phone: _____

Insurance Information:

Primary Insurance	**Secondary Insurance**
Company Name: _____	Company Name _____
Policy Holder: _____	Policy Holder: _____
Relationship to Policy Holder: _____	Relationship to Policy Holder: _____
Policy Holder's SS# _____	Policy Holder's SS# _____
Policy Holder's D.O.B. _____	Policy Holder's D.O.B _____

Do we have permission to:

Leave a message on your answering machine at home? ☐ Yes ☐ No
Leave a message at your place of employment? ☐ Yes ☐ No
Discuss your medical condition with any member of your household? ☐ Yes* ☐ No

*If yes, with whom: _____ Relationship: _____

Please present <u>your insurance</u> card(s) and your <u>photo identification</u> to the receptionist.

_____ _____
Patient Signature Date