

PATIENT INFORMATION:

(PLEASE PRINT)

Name: _____ **Date of Birth** ___/___/___
(last) (first)(middle initial)

Mailing Address: _____
(Street) (P.O. Box) (City/Town) (State) (Zip Code)

Home Phone: (____) _____ **Work Phone** (____) _____ **Cell** (____) _____

SS# _____ **Sex: Male/Female** **Marital Status** _____

Primary Care Physician _____ **Phone** _____

Address _____

PARENT/GUARANTOR OR RESPONSIBLE PARTY: *(if patient under 18 years old)**

Name: _____ **Date of Birth** ___/___/___
(last) (first) (middle initial)

Mailing Address: _____
(Street) (P.O. Box) (City/Town) (State) (Zip Code)

Home Phone: (____) _____ **Work Phone** (____) _____

SS# _____ **Sex: Male/Female** **Relationship to patient** _____

*** If there is a question as to the responsible party, it is the policy of the office that the person presenting the child for treatment is ultimately responsible for any patient balance.**

INSURANCE INFORMATION: *(Please present insurance card at time of check in)***

Primary Insurance _____ **Secondary Insurance** _____

Subscribers name _____ **Subscribers Name** _____

Subscribers Address _____ **Subscribers Address** _____

Subscribers date of birth ___/___/___ **Subscribers date of birth** ___/___/___

Relationship to patient _____ **Relationship to patient** _____

Policy number _____ **Policy Number** _____

Social Security _____ **Social Security** _____

Employers Name _____ **Employers Name** _____

Employers Phone _____ **Employers Phone** _____

****You are responsible to give accurate insurance information so that we may file a claim with your insurance company. Incorrect information that results in the rejection of your claim will become patient responsibility.**

I have been informed of the privacy policy.

Guarantor: _____ **Date** _____