PATIENT INFORMATION

Please print and complete *all* information

Patient Name: _____
First Middle Last

Mailing address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Single Married Divorced Widow (circle one) E-mail address _____

School or Employer: _____

Position: _____ Work Phone: _____

Family Physician: _____ Phone _____

Who referred you to our office? _____

Parent's or Spouse's Name: _____ Date of Birth _____

Parent/spouse Employer: _____ Phone: _____

Person responsible for payment: _____

Name of person to contact in an emergency situation (someone not in your home):

_____ Phone Number: _____

***** Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any and all copay, deductible, co-insurance, or any other balance not paid for by your insurance.*****

I have read and understand the above statement:

X_____ **Date** _____

PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST ALONG WITH YOUR INSURANCE CARDS AND PHOTO IDENTIFICATION SO THAT WE MAKE A COPY OF THEM.

THANK YOU