PATIENT INFORMATION

Patient Name: ____DOB: _____________Sex: ______

Maiden Name (if applicable): ____

Driver's License #: _________________________________ SSN: ___________________________________

Home Phone: __________________________________ Cell Phone: ________________________________

Address: ____

Employer: _______________________________________ Position:_________________________________

Employer Address: ____ Phone: ________________

Emergency Contact Information

Dependent? ___Yes ___No If yes, Guardian's Name: ____

Guardian's Phone: ______________________________ Cell Phone: _______________________________

Marital Status: ____________________________ Spouse's Name: _________________________________

Spouse's Employer: _____________________________ Work Phone: _______________________________

Emergency Contact: ____________________________________ Relationship: ______________________

Home Phone: __________________________________ Cell Phone: ________________________________

Emergency Contact: ____________________________________ Relationship: ______________________

Home Phone: __________________________________ Cell Phone: ________________________________

Insurance Information

Insured Party: _____________________________________ Relationship to Patient: __________________

Insurance Company: ____ Phone: ________________

Address: ____

Policy #: ____ Group #: ______________________________

Dual Coverage? Yes___ No___ 2nd Insurance Company: ____

Insured Party: _____________________________________ Relationship to Patient: __________________

Phone: ______________________________ Address: ____

Policy #: ____ Group #: ______________________________

Payment Method: __________________________________ Card/Check #: __________________________

PATIENT INFORMATION

Patient Name: ____

I verify that the information on the previous page is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary to provide the proper patient care. I understand that payment, proof of insurance, and/or co-pay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

Patient Signature: ____ Date: ________________________