Patient Insurance Information

PATIENT INFORMATION *(confidential)* Whom may we thank for referring you? _____

Patient's name _____ Today's Date ____/____/____

Home Address _____

City _____ State _____ Zip _____

Email Address _____ Cell Phone # ____ - ____ - ____

Social Security # ____ - ____ - ____ Date of Birth ____/____/____ Home Phone # ____ - ____ - ____

Marital Status *(check one)* ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ I am a minor

If student, name of School/College _____ State ____ ☐ Full Time ☐ Part Time

Employer (patient's or parent's) _____ Work Phone # ____ - ____ - ____

Business Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Cell Phone # ____ - ____ - ____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone # ____ - ____ - ____

Driver's License # _____ Date of Birth ____/____/____ Social Security # ____ - ____ - ____

Employer _____ Work Phone # ____ - ____ - ____

Is the responsible party currently a patient in this office? ☐ Yes ☐ No

We offer the following methods of payment. Please check the option you prefer. Payment is expected *in full* at each appointment.

(Please check one) ☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

INSURANCE INFORMATION – PRIMARY

Name of insured _____ Relationship to Patient _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Date Employed ____/____/____

Name of Employer _____ Work Phone # ____ - ____ - ____

Employer Address _____ City _____ State _____ Zip _____

Ins Company _____ Group # _____ ID # _____ Phone # ____ - ____ - ____

INSURANCE INFORMATION – SECONDARY

Name of insured _____ Relationship to Patient _____ Date of Birth ____/____/____

Social Security # ____ - ____ - ____ Employer _____ Work Phone # ____ - ____ - ____

Ins Company _____ Group # _____ ID # _____ Phone # ____ - ____ - ____