Patient Information Form

Patient Information

Patient Name: ______________________________

Social Security #: ____________________ Driver's License #: ____________________

Phone: (Hm): ______________ (Wk) ______________ (Cell): ______________

Sex: ____________ Date of Birth: ______________ Family Status: ______________

Address: ____________________________ City: ____________________

State: ____________________________ Zip: ____________________

E-mail address: ______________________________

Spouse's Name: ____________________________ Wk phone: ____________________

Nearest relative not living with you: ____________________ Phone: ____________________

Nearest friend not living with you: ____________________ Phone: ____________________

Physician: ____________________________ Phone: ____________________

Landlord: ____________________________ Phone: ____________________

Whom may we contact in case of an emergency? ______________ Phone: ____________________

Financially Responsible Person's Information

Who is responsible for this bill? ____________________ Relationship to Patient: ______________

Phone (if different from above): (Hm): ______________ (Wk): ____________________

Address (if different from above): ______________________________

Insurance Carrier (if applicable): ______________________________

Social Security Number of Insured: ______________________________

Insured's Date of Birth: ______________________________

Group Number: ____________________________ Member Number: ______________

Insurance Phone Number: ______________________________

Secondary Insurance Carrier (if applicable): ______________________________

Name of Secondary Insured: ______________________________

Social Security # of Secondary Insured: ______________________________

Date of Birth of Secondary Insured: ______________________________

Group Number: ____________________________ Member Number: ______________

Employment Information

Employer: ____________________________ Occupation: ____________________

Address: ______________________________

Phone: ______________ How long have you worked there? ______________

Spouse/Insured's Employer: ____________________ Occupation: ____________________

Phone: ____________________ How long have they been employed there? ______________

Referral Information

Whom may we thank for referring you to our office? ______________________________

☐Yellow pages ☐Newspaper ☐School ☐ Work ☐Internet ☐ Other____________________

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

______________________________ ______________

Signature Date

______________________________ ______________

Parent Signature (if minor) Date