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CONFIDENTIAL PATIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Date:_____

Name:_____DOB:_____MaritalStatus:_____

Name of Parent (if minor):_____City_____State_____Zip_____

Current Address:_____City_____State_____Zip_____

Phone: (permanent) _____(work)_____ (temporary)_____

SS#: _____ Sex: ____ email: _____

Occupation_____Employed by:_____

Work Address _____ City_____ State_____ Zip_____

Name of nearest relative not living with you:_____Phone:_____

Name of Spouse (or parent for minor child)_____SS#:_____

Occupation_____Employed by_____ Phone _____

Whom may we contact in case of emergency?_____Work #_____

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES. I WILL BE PAYING MY INITIAL VISITS WITH:

Cash _____ Check _____ Credit Card _____

At time of payment, you will be given an invoice from our office. This will show the diagnosis, services, and charges for that day. If you have coverage you can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office in dealing with any possible follow up inquiries from your insurance company regarding your claims.

Do you have insurance? Yes _____ No _____

Insurance Company_____Phone:_____

Name of Primary Insured_____Relationship to Patient_____

SS#_____Policy#_____

Secondary Insurance Company_____Phone:_____

Name of Primary Insured_____Relationship to Patient_____

SS#_____Policy#_____