

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient Name _____

SS #/SI _____ Male Female Birthdate _____ Home phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

E-Mail _____ Cell phone _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Occupation _____

Patient's or parent/spouse's employer _____ Work phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

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

Address _____ Birthdate _____

Home phone _____ Cell phone _____

Employer _____ Work phone _____

Insurance Information *(Cosmetic procedures not applicable)*

Name of insured _____ Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Secondary Insurance

Name of insured _____ Relationship to patient _____

Birthdate _____ SS #/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. employer _____ City _____ State/Prov. _____ Zip/P.C. _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ Date _____
Signature of patient or parent/guardian if minor