|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | | | | | | | | | | | | | | | |
| Date: | | |  | | |  | |  | | | | New Patient | | Update |  |
| Patient: | | |  | | |  | |  | | | |  | |  |  |
|  | | | Last | | | First | | MI | | | | Preferred | | Title |  |
|  | | | Male Female | | | Child\* Student\*\* | | | | | Single Married Divorced Widowed | | | | |
| \*If Child, provide parent/guardian name(s) below: | | | | | | | | | \*\*If Student, please complete: Full-time Part-Time | | | | | |  |
|  |  | | | | | |  | |  |  | | | | |  |
|  | Parent/Guardian Name(s) | | | | | |  | |  | School/Location | | | | |  |
| Patient Date of Birth: | | | | |  | | | Patient SSN: | | | |  | | |  |
| Address: | |  | | | | | | | | | |  | | |  |
|  | | Address Line 1 | | | | | | | | | |  |  | |  |
|  | |  | | | | | | | | | | Home: |  | |  |
|  | | Address Line 2 | | | | | | | | | | Cell: |  | |  |
|  | |  | | | |  | |  | | | | Other: |  | |  |
|  | | City | | | | ST | | ZIP Code | | | | Pager: |  | |  |
| E-Mail: | |  | | | | | | | | | | Fax: |  | |  |
| Referral? | | | | Yes  No | | Referred by: | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **emergency Information** | | | | | |
| In case of emergency, please provide information for the nearest relative or designated contact person not at the patient’s address: | | | | | |
|  |  |  | Tel: |  |  |
|  | Name | Relationship |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **employment Information** | | | | | | | |
| Employer: |  | | Occupation: |  | | |  |
| Address: |  | | | |  | |  |
|  | Address Line 1 | | | | Work: |  |  |
|  |  | | | | Direct: |  |  |
|  | Address Line 2 | | | | Other: |  |  |
|  |  |  |  | | Pager: |  |  |
|  | City | ST | ZIP Code | | Fax: |  |  |
| E-Mail: |  | | | |  |  |  |
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| **insurance Information** | | | | | | | | | | | | | | | |
| Subscriber: |  | | | | |  | |  | | | |  | |  |  |
|  | Last | | | | | First | | MI | | | | Preferred | | Title |  |
| Subscriber Date of Birth: | | |  | | | | | Subscriber SSN: | | | |  | | |  |
| Subscriber Employer: | | |  | | | | | | | | | | | |  |
| Patient Relationship to Subscriber: | | | | | Self Spouse Child Other | | | | | | | | | |  |
| **Primary Insurance Carrier:** | | | |  | | | | | | | | | | |  |
| Group/Policy No.: | |  | | | | | | | ID No.: |  | | | | |  |
| Address: |  | | | | | | | | | | Tel: | |  | |  |
|  |  | | | | | | | | | | Toll-free: | |  | |  |
|  |  | | | | |  |  | | | | Fax: | |  | |  |
|  | City | | | | | ST | ZIP Code | | | |  | |  | |  |
| **Secondary Insurance Carrier:** | | | |  | | | | | | | | | | |  |
| Group/Policy No.: | |  | | | | | | | ID No.: |  | | | | |  |
| Address: |  | | | | | | | | | | Tel: | |  | |  |
|  |  | | | | | | | | | | Toll-free: | |  | |  |
|  |  | | | | |  | |  | | | Fax: | |  | |  |
|  | City | | | | | ST | | ZIP Code | | |  | |  | |  |