



Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F  
Social Security #: \_\_\_\_\_ Marital Status: Single Married Divorced Widowed  
Home Address: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

If not employed, is the patient \_\_\_\_\_ Retired? \_\_\_\_\_ A Student? \_\_\_\_\_ A Homemaker? Or \_\_\_\_\_ Unemployed?

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address (on back of your card): \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**IF THE PATIENT IS NOT THE SUBSCRIBER TO THE INSURANCE, PLEASE FILL OUT THIS SECTION !!**

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Home Address & Phone #: (if different than patient's): \_\_\_\_\_  
Relationship to patient (Circle One) Spouse Parent Other (please fill in) \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SECONDARY INSURANCE**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address (on back of your card): \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**IF THE PATIENT IS NOT THE SUBSCRIBER TO THE INSURANCE, PLEASE FILL OUT THIS SECTION !!**

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Home Address & Phone #: (if different than patient's): \_\_\_\_\_  
Relationship to patient (Circle One) Spouse Parent Other (please fill in) \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:**

Who is responsible for payment of balances? (The responsible party can never be a child)

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

**I acknowledge the above information is correct and I accept financial responsibility for any services offered for my dependent or myself.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_