

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Married Single Other: _____
Spouse Name: _____ Spouse SSN: _____

Responsible Party Information

The following is for: the patient the person responsible for payment
Name: _____
 Male Female
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Email Address: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Phone
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Location Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____