PATIENT INFORMATION
PLEASE PRINT ALL INFORMATION

Date _____ Patient Name _____ Patient # _____

SS #/ SIN _____ [] Male [] Female Birthdate _____ Home Phone _____

Address _____ City _____ State ____ Zip _____

E – Mail _____ Cell Phone _____

Check appropriate box [] Minor [] Single [] Married [] Divorced [] Widowed [] Separated

Parent / Guardian's employer _____ Work phone _____

Business Address _____ City _____ State ____ Zip _____

Spouse or parent/guardian's name _____

Employer _____ Work Phone _____

If patient is a student, name of school / college _____ City _____ State ____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

In case of a medical emergency, if patient is of school age 15+, it is all right to treat in my absence. X _____ _____

Parent or guardian signature Date

Responsible Party

Person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License _____Birth date _____ Financial Institution _____

Employer _____ Work Phone _____

Is this person currently a patient at our office? [] Yes [] No

Insurance Information

Name of insured _____ Relationship _____

Birth date _____ SS # / SIN _____ Date Employed _____

Name of Employer _____ Work phone _____

Address of Employer _____ City _____ State ____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Co. Address _____ City _____ State ____ Zip _____

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 clinic.

X _____ _____

Signature of patient or parent/guardian **Date**