

# PATIENT INFORMATION FORM

Please Print and Complete All Entries

Patient Name (Last-First-Middle) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Social Security No. \_\_\_\_\_

Responsible Party if Minor \_\_\_\_\_ Spouse if Married \_\_\_\_\_

Home Address - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Were you referred by a doctor? Yes \_\_\_\_ No \_\_\_\_ If yes name: \_\_\_\_\_

Family Doctor \_\_\_\_\_ Address \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company Name \_\_\_\_\_

Please Circle HMO PPO Other \_\_\_\_\_

Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Relationship of Insured to Patient \_\_\_\_\_

If you have insurance your co-pay is expected at time service is rendered. If you do not have insurance payment is expected at time service is rendered.

IMPORTANT: Please list any drug allergies \_\_\_\_\_

\_\_\_\_\_

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