



Patient's Name (Last, First, MI): \_\_\_\_\_

Patient's Home Phone Number: \_\_\_\_\_ Alternate Phone Number ( cell or  work): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Marital Status:  Married  Single  Divorced  Widowed

Patient's Employer: \_\_\_\_\_

Employment Status:  Full time  Part time  Unemployed  
 Retired  Student  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_

Patient is Subscriber/Policy Holder: Y N

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

Patient is Subscriber/Policy Holder: Y N

**INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card**

Subscriber/ Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

His or Her Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**RELEASE OF INFORMATION**

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient / Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_