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## PATIENT INFORMATION

### WELCOME TO OUR OFFICE!

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

Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

If patient is minor, give parent or guardian's name: \_\_\_\_\_

Patient Email: \_\_\_\_\_ Responsible Party Email: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Marital Status \_\_\_\_\_

Residence: Street \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address: Street \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address: \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 years): Street \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_ Spouse's Birth Date \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage?  Yes  No If Yes, please continue:

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature (Parent's signature, if minor) \_\_\_\_\_ Date \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.