



**PATIENT INFORMATION**

*(Please Print)*

\_\_\_\_\_  
Name (First, Middle, Last) **M / F**

\_\_\_\_\_  
Mailing Address

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

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

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

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Email Address

**IN CASE OF EMERGENCY CONTACT**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number Relationship

**PRIMARY INSURANCE  
POLICY HOLDER INFORMATION**

\_\_\_\_\_  
Policy Holders Name (First, Last) **M / F**

\_\_\_\_\_  
Mailing Address

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

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

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

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

**RESPONSIBLE PARTY / PARENT  
INFORMATION (IF MINOR)**

\_\_\_\_\_  
Name (First, Middle, Last) **M / F**

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State ZIP

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

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

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Email Address

**PRIMARY CARE PHYSICIAN**

\_\_\_\_\_  
Physician's Full Name

\_\_\_\_\_  
Phone Number

**SECONDARY INSURANCE  
POLICY HOLDER INFORMATION**

\_\_\_\_\_  
Policy Holders Name (First, Last) **M / F**

\_\_\_\_\_  
Mailing Address

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

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

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

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

**DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CARE OR TREATMENT WITH ANY PARTY BESIDES YOURSELF?**     YES    OR     NO

**FIRST & LAST NAME:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**I HAVE READ THE BILLING AND HIPAA PRIVACY INFORMATION (See following page)**

\_\_\_\_\_ **DATE** \_\_\_\_\_  
**PATIENT SIGNATURE (PARENT IF MINOR)**