WELCOME

Today's Date: _____

---------- TELL US ABOUT YOUR SELF ----------

Name: _____ Nickname: _____

Birthdate: _____ Age: _____Male_____ Female _____ SSN: _____

Address: _____Zip_____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Referred by: _____

Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name: _____ Phone #: _____

---------- IN CASE OF EMERGENCY ----------

Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____ Work #: _____

Primary Doctor's Name: _____Phone #: _____

---------- ACCOUNT INFORMATION ----------

(Person ultimately responsible for account)

Name: _____ SSN #: _____ DL #: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____Relationship to Patient: _____

Employer: _____ Occupation: _____

Employer Address: _____

_____ (Initials) I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I understand that I am solely responsible for any balance not paid for by my insurance company.

---------- INSURANCE INFORMATION ----------

Primary:	Secondary:
Insurance Name: _____	Insurance Name: _____
Insurance Address: _____	Insurance Address: _____
_____	_____
INS Phone #: _____	INS Phone #: _____
Group #: _____ Id #: _____	Group #: _____ Id #: _____
Insured's Name: _____	Insured's Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insured's DOB: _____	Insured's DOB: _____
Insured's SSN #: _____	Insured's SSN #: _____
Insured's Employer: _____	Insured's Employer: _____

I, _____, hereby agree that the information given above is correct to the best of my knowledge.

Patient/ Legal Guardian Signature: _____