## -PATIENT INFORMATION-

Patient Name_____ Age_____ D.O.B____/____/____
(Last) (First) (MI)

Street Address_____ Primary Phone (____) _____

City_____ State_____ Zip Code_____ Secondary Phone (____) _____

Social Security # _____/____/_____ Marital Status_____ Maiden Name_____

E-mail _____ Employer_____

Employer's Address_____ Occupation _____

Race: Asian Black Native Pacific White Preferred Language: _____ Ethnicity: Declined Hispanic Non-Hispanic Unreported

## -RESPONSIBLE PARTY FOR THIS ACCOUNT- (if patient is a minor)

Name_____ Relationship_____

Street Address_____ Primary Phone (____) _____

City_____ State_____ Zip Code_____

Social Security # _____/____/_____ Work Phone (____) _____ E-mail _____

Employer_____ Employer's Address_____

## -EMERGENCY CONTACT- (someone not residing in the same household)

Name_____ Relationship_____ Phone (____) _____

## -INSURANCE INFORMATION- (please present ALL insurance cards to receptionist)

**PRIMARY INSURANCE**

Insurance Company_____ Office Visit Co-pay $_____ Effective Date ____/____/____

Name of Policy Holder/Insured _____ Insured Date of Birth _____/_____/_____

Relationship to Patient _____ Social Security #_____/_____/_____ Employer _____

**SECONDARY INSURANCE** (if applicable)

Insurance Company_____ Office Visit Co-pay $_____ Effective Date ____/____/____

Name of Policy Holder/Insured _____ Insured Date of Birth _____/_____/_____

Relationship to Patient _____ Social Security #_____/_____/_____ Employer _____

***Patient is responsible for notifying our office of any changes in address, telephone number(s), or insurance information. If the office is unable to contact you because of outdated or incorrect information, we cannot take responsibility for your care.***

*Patient signature*_____ *Date*_____