



To help us meet all your healthcare needs, please fill out this form in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Patient Number _____
 SS#/SIN _____ Birthdate _____ Date _____
 Address _____ City _____ Home Phone _____
 Email _____ State _____ Zip _____
 Cell Phone _____
 Check Appropriate Box: Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
 If Student, Name of School / College _____ City _____ State/Prov. _____ Full Time _____ Part Time _____
 Patient or Parent/Guardian's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
 Whom May We Thank for Referring You? _____
 Emergency Contact person _____ Phone _____

Responsible Party

Name _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Email _____ Cell Phone _____
 Driver's License # _____ Birthdate _____ Financial Institution _____
 Employer _____ Work Phone _____ SS#/SIN _____
 Is this Person Currently a Patient Yes _____ No _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash
 Personal Check
 Credit Card
 VISA
 MasterCard
 I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____
 Do You Have Any Additional Insurance? Yes _____ No _____ If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____