PLEASE PRINT

DATE: ______________________________

NAME: ____

ADDRESS: ____

CITY: ____ STATE: ____________ ZIP: ________________

HOME PHONE: (_____) ________________________ ALTERNATE PHONE: (_____) __________________________

BIRTHDATE: _____________ AGE: _____________ SEX: _________ SOCIAL SECURITY: ______________________

REFERRED BY: ____

EMERGENCY CONTACT: ______________________________________ PHONE: (_____) _________________________
(RELATIONSHIP)

EMPLOYER: ____ PHONE: (_____) _________________________

ADDRESS: _______________________________ CITY: _______________________ STATE: _______ ZIP: ____________

MARITAL STATUS: __________________________________ SPOUSE/PARENT: __________________________________

SPOUSE/PARENT EMPLOYER: ________________________________ PHONE: (_____) _________________________

SPOUSE/PARENT EMPLOYER'S ADDRESS: ____

CITY: ________________________________ STATE: ______________ SOCIAL SECURITY: ______________________

CURRENT MEDICATIONS: ____

HOSPITALIZATIONS: ____

ALLERGIES: ____

PRIMARY INSURANCE: ______________________________ POLICY NUMBER: _________________________________

CLAIMS ADDRESS: ____

CITY: ____ STATE: ____________ ZIP: ________________

SECONDARY INSURANCE: ___________________________ POLICY NUMBER: _________________________________

CLAIMS ADDRESS: ____

CITY: ____ STATE: ____________ ZIP: ________________

ADDITIONAL POLICY INFORMATION: ____

It is customary to pay for services when rendered unless other arrangements have been made with our office.

Authorization to release information: I hereby authorize release of any medical information necessary in the course of treatment. I also hereby authorize any payment for medical services provided to be made directly to the physician.

DATE: ___________________ PATIENT'S SIGNATURE: ____