

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  Male  Female Date of Birth \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Driver License # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency? \_\_\_\_\_ Home Phone \_\_\_\_\_

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

**\*If Minor (under 18)** Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Person Responsible For Account \_\_\_\_\_

Last First Middle

Relation to the Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address if Different from Patient \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber \_\_\_\_\_

Name of dependents under this plan \_\_\_\_\_

## ADDITIONAL/ SECONDARY INSURANCE

Is patient covered by additional Insurance?  Yes  No

Additional Insurance subscribers name \_\_\_\_\_

Last First Middle

Relation to the Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address if Different from Patient \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Subscriber Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of dependents under this plan \_\_\_\_\_