***Patient Information*____ Today's date:_______________**

Patient Name:____ Birth Date:___________________

Gender (M/F) _____ Social Security #:______________________ Marital Status:_____ Driver's License#:____________________

Home Address:____

City,State,Zip____

Phone #'s: Home:_______________________ Work:______________________________ Cell:___________________________

Employer/School:____ Employer/School________________________________

E-Mail address:____

Person to contact in case of emergency:____

***Referral Information*:____**

Who may we thank for referring you to our office:____

***Spouse,Parent, or Responsible Party Information*:____**

Name:____ Social Security:_____________________

Gender (M/F)_____ Marital Status:_____ Birth Date:_________________ Driver's License #:______________________________

Home address:____

City,State,Zip:____

Employer:____ Phone #:_______________________________________

Phone #'s: Home:__________________________ Work:___________________________ Cell:___________________________

E-Mail address:____

Method of Payment: Cash_____ VISA/Mastercard_____ Discover______ American Express____ CareCredit_____

(We no longer accept checks)

***Insurance Information*____**

Primary Insurance Plan name and address:____

Name of Insured Person:____ Birth Date:________________________

Insured's home address:____ City,State,Zip___________________________

Insured's Employer:____ Address:_______________________________________

Patient's relationship to insured: Self_____ Spouse_____ Child_____ Other_____ Insured's Social Security #:____________________

***Secondary Insurance*____**

Insurance Plan Name and Address:____

Name of Insured Person:____ Birth Date:__________________________

Insured's home address:____ City,State,Zip_____________________________

Insured's Employer:____ Address:_______________________________________

Patient's relationship to insured: Self_____ Spouse_____ Child_____ Other_____ Insured's Social Security #:____________________

Insurance Plan Name and Address:____

**We need a copy of all insurance cards and Photo ID (Parent's ID if patient is a minor)