

**Patient Information**

How were you referred to our practice? \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: Male / Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

**Alternate Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Parent or Responsible Party Information** *(for treatment of minors)*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: Male / Female

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

**Insurance Information:**

Primary Policy: \_\_\_\_\_ Secondary Policy: \_\_\_\_\_

Identification #: \_\_\_\_\_ Identification #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_