Patient Information **Date:** _____

*How were you referred to our practice?*_____

Name:_____ Date of Birth:_____

Age:_____ Social Security #:_____ Sex: Male / Female

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Alternate Phone:_____

Alternate Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Primary Care Doctor: _____ Phone: _____

Preferred Pharmacy: _____ 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:_____

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:_____Alternate Phone:_____