## PATIENT INFORMATION

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

### PERSONAL

Name______________________________________________
Last First MI (Preferred)

Birthdate______________ SS#__________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_______________ Wireless Phone_________________ Wireless Carrier________________

Email______________________________________________

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

______________________________________________

(If someone referred you here, please write down their name so we can thank them.)

### ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address______________________________________________

Address 2______________________________________________

City__________________________ State_______ Zip__________________

Home Phone______________________

### INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [X] Child

Subscriber Name_________________________________ Subscriber ID # ____________________

Insurance Company ____________________________________

Employer________________________ Subscriber Birthdate_____________

Please present insurance card to receptionist.

### INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_________________________________ Subscriber ID # ____________________

Insurance Company ____________________________________

Employer________________________ Subscriber Birthdate_____________

Comments:

* For my convenience, this office may release my information to my insurance company, and recieve payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature ________________________________________ Date ____________________