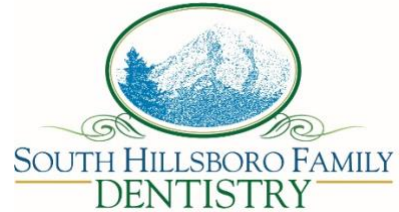


New Patient Information



Patient Name _____
Name of person responsible for this account: _____
Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone#: _____ Cell Phone#: _____
Email: _____
Birthdate: _____ Last four of SSN#: _____
 Single Married Minor
Driver's License#: _____
Employer: _____ Work Phone: _____
Employer Address: _____
Emergency Contact Name: _____ Cell Phone#: _____

Check your preferred method of payment:

Credit Card Cash/Check Care Credit Other; I wish to discuss my payment options

Insurance information

Name of insured: _____ Relationship to Patient: _____
Birthdate: _____ SSN # (Last 4 if required): _____
Name of Employer: _____ Date Employed: _____ Phone #: _____
Insurance Company: _____ Group#: _____ Policy#: _____
Address: _____ City: _____ State: _____ Zip: _____

Do you have any additional insurance? YES NO

If yes, please complete the following:

Name of insured: _____ Relationship to Patient: _____
Birthdate: _____ SSN # (Last 4 if required): _____
Name of Employer: _____ Date Employed: _____ Phone #: _____
Insurance Company: _____ Group#: _____ Policy#: _____
Address: _____ City: _____ State: _____ Zip: _____