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: _____