New Patient Information

Patient Name: _____
Preferred Name: _____
Name of person responsible for this account: _____
Relationship to patient: _____

Address: _____
City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone#: _____

Email: _____

Birthdate: _____ SSN#: _____
☐ Single ☐ Married ☐ Minor

Employer: _____ Work Phone: _____
Employer Address: _____
Emergency Contact Name: _____ Cell Phone#: _____

How did you hear about us?
☐ Flyers ☐ Web Search ☐ Insurance Co. ☐ Friend/Family ☐ Other_____

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 #: _____
Name of Employer: _____ Date Employed: _____ Phone #: _____
Insurance Company: _____ Group#:_____ Policy#: _____
Do you have any additional insurance? ☐ YES ☐ NO

If yes, please complete the following:
Name of insured: _____ Relationship to Patient: _____
Birthdate: _____ SSN #: _____
Name of Employer: _____ Date Employed: _____ Phone #: _____
Insurance Company: _____ Group#:_____ Policy#: _____