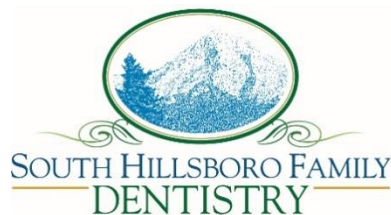


New Patient Information



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#: _____