PATIENT INFORMATION (CONFIDENTIAL)

NAME_____DATE _____
FIRST MI LAST

ADDRESS_____CITY_____STATE____ZIP_____

E-MAIL_____CELL PHONE_____HOME PHONE_____

SS#_____BIRTH DATE_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. P.T., NAME OF SCHOOL _____ CITY _____ STATE_____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER_____WORK PHONE_____

BUSINESS ADDRESS_____CITY_____STATE____ZIPCODE_____

SPOUSE OR PARENT'S/GUARDIAN'S NAME_____EMPLOYER_____WORK PHONE____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATION TO PT_____
ADDRESS_____HOME PHONE_____
DRIVER'S LICENSE #_____BIRTHDATE_____SS#_____
EMPLOYER_____WORK PHONE_____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____
BIRTHDATE_____SS#_____DATE EMPLOYED_____
NAME OF EMPLOYER_____CITY_____STATE_____ZIPCODE____
EMPLOYER ADDRESS_____CITY_____STATE_____ZIPCODE____
INSURANCE CO._____TEL. #_____ GROUP # _____POLICY/I.D.#_____
HOW MUCH IS YOUR DEDUCTIBLE?_____HOW MUCH HAVE YOU USED?_____MAX ANNUAL BENEFIT?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES COMPLETE THE FOLLOWING:

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____
BIRTHDATE_____SS#_____DATE_____
NAME OF EMPLOYER_____TEL# _____
EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____
INSURANCE CO._____TEL. #_____GROUP # _____POLICY/I.D. #_____
INS. CO. ADDRESS_____CITY_____STATE_____ZIP_____

HOW MUCH IS YOUR DEDUCTIBLE?____HOW MUCH HAVE YOU USED?___MAX ANNUAL BENEFIT?_____

X_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR