WELCOME TO OUR OFFICE

To help us meet all your healthcare needs, please fill out this form **completely** in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Full Name_____ Preferred Name_____ Date_____

SS#/SIN_____ Birthdate_____ Home Phone_____

Address_____ City_____ State____ Zip_____

Email_____ Cell Phone_____

Circle Appropriate Status : Minor Single Married Separated Divorced Widowed

If Student, Name of School/College_____ City_____ State_____

Patient or Parent/Guardian's Employer_____ Work Phone_____ EXT._____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer Work Phone_____ EXT.____

Whom May We Thank for Referring You? _____Phone _____

Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient _____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Driver's License#_____ Birthdate_____

Employer_____ Work Phone_____ SS#/SIN_____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For you convenience, we offer the following methods of payment.
Please check the option you prefer. **Payment is required in full at each appointment**.

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ I wish to discuss with office

AS A COURTESY TO OUR PATIENTS WE WILL SUBMIT YOUR TREATMENT FOR PAYMENT TO YOUR INSURANCE COMPANY. PLEASE BE AWARE THAT YOUR INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL AND THAT YOU ARE RESPONSIBLE FOR THE DIFFERENCE.

PATIENT SIGNATURE _____

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birth date_____ SS#/SIN _____ Date Employed_____

Name of Employer_____ Union or Local#_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group# _____ Policy/ID#_____

Ins. Co. Address_____ City_____ State_____ Zip_____