Patient Information

* Denotes required information

ABOUT YOU

Today' Date _____ *Sex ☐Male ☐Female Patient Number_____

*FULL LEGAL NAME – First_____ *M.I._____ *Last_____

Prefer to be called_____ Social Security # _____ - _____ - _____

Email Address _____

*Date of Birth (MM/DD/YY) _____ Age_____ Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

*Street Address _____

*City _____ *State _____ *Zip code _____

*Home Phone (_____) _____ Cellular Phone (_____)_____

How were you referred to us / by whom? _____

Privacy Statement Received? ☐Yes - Date _____ ☐No (You will receive the HIPAA privacy statement at the clinic)

EMPLOYMENT

Employer _____ Occupation _____

Employer's Address _____City_____St_____ Zip_____

Work Phone (_____) _____ Employment Status ☐Full time ☐Part time ☐Not employed ☐Retired ☐Military

**** Special Note: If you have your current insurance card, bring that with you for us to make a copy and you will not need to fill out the insurance info section.**

INSURANCE INFO

***Primary** Insurance Co. Name _____ Phone # (_____)_____

*Insurance ID _____ Group/Policy # _____

*Insurance Address _____*City_____*St_____*Zip_____

*Insured's Name (if different than patient)_____Insured's SS#_____

*Insured's Address_____*City_____*St_____*Zip_____

*Insured's Phone # (_____)_____ Sex ☐Male ☐Female

Relation to Insured_____ *Date of Birth _____ Age_____

***Secondary** Insurance Co. Name _____ Phone # (_____)_____

*Insurance ID _____ Group/Policy # _____

*Insurance Address _____*City_____*St_____*Zip_____