|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | **Patient Name: Last** | | | | | | | | | | **First** | | | | | | | | **MI** | |
| DOB  / / | Age | | | Sex  Male / Female | | | | | | Social Security # | | | | Email Address | | | | | |
| Mailing Address: (Street or box) | | | | | | | | | City | | | | | State | | | Zip Code | | |
| Home Phone | | | Cell Phone | | | | | | | | Employer: | | | | | | | | |
| Work Phone: | | | | | | | | |
| Marital Status: (circle)  Single Married Divorced Widowed | | | | | | | Primary Care Doctor | | | | | Who Referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Website Google Insurance Doctor Attorney | | | | | | | |
| Have you been a patient here before: Y / N If so, when: | | | | | | | | | | | |
| **Responsible Party** | **Complete for a minor or for a patient with a legal representative:** | | | | | | | | | | | | | | | | | | | |
| Name: Last | | | | | | | | First | | | | | MI | | | Relationship to Patient | | | |
| Mailing Address: (Street or box) | | | | | APT # | | | City | | | | | State | | | Zip code | | | |
| Phone #: | | | | | | | | Email: | | | | | | | | DOB: | | | |
| **Insurance Information** | **Primary Ins Co: or Auto Ins: PIP** | | | | | | **DOI:** | | **Secondary Ins Co: or Auto Ins: At fault** | | | | | | | | | | | **DOI:** |
| ID/Claim # | | Group # | | | | | | ID/Claim # | | | | | | | Group # | | | | |
| Effective Date | | Subscriber’s Name | | | | | | Effective Date | | | | | | | Subscriber’s Name | | | | |
| Relationship to Patient | | Subscriber’s DOB  / / | | | | | | Relationship to Patient | | | | | | | Subscriber’s DOB  / / | | | | |
| Subscriber’s Employer | | Work Phone | | | | | | Subscriber’s Employer | | | | | | | Work Phone | | | | |
| **Authorized Persons, & Emergency** | **Emergency contacts: (please include one that does not live with you)** | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | Relationship to Patient | | | | | Phone # | | | | |
| Name | | | | | | | | | | Relationship to Patient | | | | | Phone # | | | | |
| **I authorize the physician(s) and staff to discuss information regarding my medical condition, treatment, account and appointment information to the following listed below: (please include spouse if applicable)** | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | Relationship to Patient | | | | | Phone # | | | | |
| Name | | | | | | | | | | Relationship to Patient | | | | | Phone # | | | | |

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***(Please sign acknowledging that the above information is correct and current)***