

Please place "SAME" in spaces where information is duplicated from other side

Responsible Party Information (Person responsible for payment)

Name _____ Currently a Patient in this office? Yes No
Last First Middle

Relationship to Patient _____ Social Security # _____ Birthdate _____

Residence Address _____ Home Phone (____) _____
Street City State ZIP

Mailing Address _____ How long at current residence? _____
Street City State ZIP

Previous Address _____ How long at previous residence? _____
Street City State ZIP

Occupation _____ Work Phone (____) _____

Employer _____ How long employed _____

Spouse's Name _____ Currently a Patient in this office? Yes No
Last First Middle

Relationship to Patient _____ Social Security # _____ Birthdate _____

Occupation _____ Work Phone (____) _____

Employer _____ How long employed _____

Insurance Information

Do you have (circle one): Single Coverage Complete section 1 Dual Coverage Complete sections 1 & 2 No Insurance Proceed to "Emergency Information"

1. Insured's Name _____ Insured's SS# _____
Last First Middle

Insurance Company Name _____ Group # _____

Insurance Co. Address _____ Phone (____) _____
Street City State ZIP

2. Insured's Name _____ Insured's SS# _____
Last First Middle

Insurance Company Name _____ Group # _____

Insurance Co. Address _____ Phone (____) _____
Street City State ZIP

Emergency Information

Person to contact in case of emergency _____ Home Phone (____) _____

Relationship to patient _____ Work Phone (____) _____

FOR OFFICE USE ONLY

NOTES: _____

PATIENT I.D. # _____

CODE: A - B - C