

We're Glad to have you as a patient!

Name: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone: _____ Would you like to receive text messages _____

Birthdate: _____ Social Security #: _____

Email: _____

Mailing Address: _____ City, State, Zip _____

Are you: Minor Married Divorced Widowed Single

Are you: Employed Full-time Employed Part-time Unemployed Student Retired

Place of Employment: _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Primary Insurance _____ CoPay _____

Name of Insured _____ ID Number _____

Birthdate _____ Social Security Number _____

Secondary Insurance _____

Name of Insured _____ ID Number _____

I understand that office policy states that appointments cancelled without 24 hours notice will be charged a \$25 fee.

Signature: _____

Family Member/Contact person (authorized to view your records):

Name & phone number _____