

Please Print, Fill out and return to office for your first Visit or if information changes

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient Name _____ Patient # _____
SS #/SIN _____ Male Female Birthdate _____ Home phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
E-Mail _____ Cell phone _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient's or parent/guardian's employer _____ Work phone _____
Business address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or parent/guardian's name _____ Employer _____ Work phone _____
If patient is a student, name of school/college _____ City _____ State/Prov. _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
E-Mail _____ Cell phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____
Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? Yes No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____

Signature of patient or parent/guardian if minor

_____ Date