

PATIENT INFORMATION

DATE _____

LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

BIRTHDAY ___/___/___ SOCIAL SECURITY # _____

MARITAL STATUS S M D W

SPOUSE'S NAME _____

PERSON RESPONSIBLE FOR BILL _____

ADDRESS _____ CITY _____ ZIP _____

YOUR SIGNATURE ON THIS FORM WILL SERVE AS OUR "SIGNATURE ON FILE" FOR
INSURANCE FORMS _____

****IF YOU HAVE INSURANCE OUR OFFICE WILL BILL AND ACCEPT PAYMENT DIRECTLY
FROM THEM IF THE SERVICES QUALIFY FOR COVERAGE. ANY CHARGES NOT COVERED
ARE PAYABLE BY THE PATIENT. YOUR SIGNATURE HERE WILL SERVE AS YOUR
AGREEMENT TO PAY FOR SERVICES AND MATERIALS NOT COVERED.**

_____ DATE _____

WERE YOU REFERED TO OUR OFFICE? IF YES, BY WHOM?
