Patient Information

Date_____

Name (last)_____(first)_____(middle initial)_____

How would you like to be addressed?_____

Birth date_____Social Security #_____

Who referred you to our office?_____Student I.D.#_____

Address (number & street)_____

(city)_____(state)_____(zip code)_____

(E-mail address)_____

Home phone(_____)_____-_____(Business phone)(_____)_____-_____

Other phone # (pager, cell, fax) (_____)_____

Employer (name)_____Occupation_____

(address)_____(city)_____(state)_____(zip)_____

Emergency Contact

Name_____Telephone(_____)_____-_____

Name and Address of party responsible for payment if different from above:

Name_____Home phone(____)_____Business(_____)_____

Address_____(city)_____(state)_____(zip)_____

Relationship to patient_____(Employer name)_____(Title)_____

Insurance Information

Primary Coverage	Secondary Coverage
Subscriber name_____	_____
Subscriber Social Security #_____-_____-_____	_____-_____-_____
Subscriber Date of Birth_____	_____
Name of Insurance Company_____	_____
Phone # of Ins Co._____	_____
Group number_____	_____

Please turn this page over to complete Health History