



Section 1:	Patient Information
Date: _____	
Name: _____ I go by: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Phone(____) _____ Work Phone(____) _____ Cell Phone(____) _____	
The best time to contact me is _____ Social Security Number: _____	
Check one <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
If student, name of school: _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT	
Spouse or parent's name: _____ Employer _____	
Whom may we thank for referring you? _____	

Section 2	Responsible Party/ Emergency Contact
Relationship to patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Address: _____	
City: _____ State: _____ Zip: _____ Phone(____) _____	
Employer: _____ Work Phone(____) _____	

Section 3	Insurance Information
Name of insured: _____ DOB: _____	
Relationship to Patient: _____ SSN#: _____	
Insurance company: _____ Grp#: _____ ID#: _____	
INS Co. Address: _____ INS Co. Phone _____	
-Do you have any Additional Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes, please complete-	
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____	
Insurance Company: _____ Grp#: _____ ID#: _____	
INS Co. Address: _____ INS Co. Phone: _____	