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| Today’s date: |
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| PATIENT INFORMATION |
| Patient’s Legal Last Name: | First: | MI: | Date of Birth: | Marital status (circle one) |
|  | Single / Mar / Div / Widow |
| Home Phone: | Cell Phone:  | Email address:  |
| Would you like to receive text message alerts?  Yes  No | Would you like to be enrolled in our Patient Portal?  Yes  No |
| Street address: | City: |  State: |  ZIP Code: |
| Employer:  | Employer Phone:  |
| Patient’s Spouse/Significant Other (if applicable):  | Phone Number:  |
| **If Patient Is A Minor:** |
| Mother’s Name: | Address (if different from patient) and Phone Number:  |
| Father’s Name:  | Address (if different from patient) and Phone Number: |
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| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist.) |
| Primary Insurance:  | Policy Holder’s Name: | Date of Birth: |
| Patient’s relationship to subscriber:  Self  Spouse  Child  Other |
| Secondary insurance (if applicable): | Policy Holder’s Name: | Date of Birth: |
| Patient’s relationship to subscriber:  Self  Spouse  Child  Other |
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| IN CASE OF EMERGENCY |
| Name of friend or relative: | Relationship to patient: | Home phone: | Cell phone:  |