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| Today’s date: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 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: | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | |
| Name of friend or relative (**Not living at same address**): | | | | | | Relationship to patient: | | | Home phone: | | Cell phone: | |