

## PATIENT INFORMATION SHEET

Thank you for choosing our office! In order to serve you properly, we need the following information.  
PLEASE PRINT. All information will remain confidential.

Patient Legal Name \_\_\_\_\_ Birth Date \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

Mailing Address \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip-code \_\_\_\_\_ - \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone or alternate number (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Marital Status: Minor S M W D Other (Please circle one) Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**ANY KNOWN DRUG ALLERGIES:** \_\_\_\_\_

**Is patient under 18 years of age? YES NO (If yes, please complete the following)**

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

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### INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (must have to file insurance)

Insurance Co. Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Group# \_\_\_\_\_ Contract/ID # \_\_\_\_\_

**Do you have additional Insurance? YES NO (If yes, please complete the following)**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (must have to file insurance)

Insurance Co. Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_ Contract/ID # \_\_\_\_\_

**PLEASE READ AND SIGN SECOND PAGE**