Date: ______________

Last Name: ____________________ First Name: ____________________ M.I. ______ File #: ________

Street: ____________________________ City : ____________________ State ______ Zip __________

Home Phone: ________________ Office Phone: ________________ Cell Phone: ________________

Email: ______________________________ Fax: __________________ Pager: ________________

SS #: ______________________ Date of Birth: ____________________ Gender: ________________

Marital Status: ____________ Occupation: ______________________

How did you hear about our practice? ____

May we leave a message on your home answering machine? Yes No
May we leave a message for you at work to call us? Yes No
May we leave a message on your cell phone answering machine? Yes No
May we contact you via email? Yes No
May we contact you via text messaging? Yes No
May we discuss your medical condition with another person? Yes No

If yes, whom ______________________________________ Relationship ______________________

Person to notify in an emergency ______________________________ Relationship ______________

Phone # ________________________

If patient is a minor please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Last Name, First Name ____ SS# __________________

Street Address: ____________________________ City: ______________ State ______ Zip ______

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Policy Holder (if different from patient or responsible party) ______________________________

Policy Holder's Date of Birth: _____/_____/_____ SS# ______________________________

Employer of Policy Holder ______________________________ Work Phone __________________

Patient's Relationship to Policy Holder ____

Referring Doctor: ____

Preferred Pharmacy: ____

Preferred Lab: ____

Please present this form with your insurance card and driver's license to our receptionist. Thank you!