



**CONFIDENTIAL PATIENT INFORMATION  
PATIENT INFORMATION (PLEASE PRINT)**

**DATE:** \_\_\_\_\_

NAME: \_\_\_\_\_ SUFFIX: \_\_\_\_\_  
LAST FIRST MIDDLE

LOCAL#: \_\_\_\_\_ HM PHONE#: \_\_\_\_\_ CELL PHONE# \_\_\_\_\_

**MAILING ADDRESS INFORMATION:**

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**IF YOU ARE VISITING THE AREA AND HAVE ANOTHER HOME ADDRESS PLEASE LIST BELOW:**

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PRIMARY PHARMACY: \_\_\_\_\_ SECONDARY PHARMACY: \_\_\_\_\_

SS# \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
WE NEED IN ORDER TO FILE YOUR INSURANCE

SEX: MALE FEMALE MARITAL STATUS: (please circle) Married Single  
Divorced Widow

RACE: (CIRCLE ONE) American African-American Asian Indian Mexican Other: \_\_\_\_\_

ETHNICITY: \_\_\_\_\_ LANGUAGE: \_\_\_\_\_ DOMINANT HAND: \_\_\_\_\_

NAME OF SPOUSE / PARENT: \_\_\_\_\_  
CIRCLE ONE

PLACE OF EMPLOYMENT: \_\_\_\_\_ WK PH# \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:**

RESPONSIBLE PARTY'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ - \_\_\_\_\_

PHONE NUMBERS: \_\_\_\_\_ SS#: \_\_\_\_\_

INSURANCE TO BE FILED: 1) \_\_\_\_\_ POLICY#: \_\_\_\_\_

2) \_\_\_\_\_ POLICY#: \_\_\_\_\_

SUBSCRIBER'S NAME: 1) \_\_\_\_\_ DATE OF BIRTH REQUIRED: \_\_\_/\_\_\_/\_\_\_  
(name as shown on card)

SUBSCRIBER'S NAME: 2) \_\_\_\_\_ DATE OF BIRTH REQUIRED: \_\_\_/\_\_\_/\_\_\_

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PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR CHART  
ALL PAYMENTS INCLUDING CO-PAYMENTS/DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. WE DO ACCEPT MANY INSURANCES  
HOWEVER IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY TO FIND OUT IF WE ARE CONTRACTED WITH  
YOUR INSURANCE CARRIER OR NOT. IF YOUR INSURANCE OR ADDRESS/PHONE # CHANGES, YOU MUST NOTIFY US AS SOON AS  
POSSIBLE. IF THERE IS NO PAYMENT FROM YOUR INSURANCE BECAUSE YOU'RE INSURANCE CHANGED OR IF THEY DO NOT RESPOND  
IN A TIMELY MANNER YOU ARE RESPONSIBLE FOR THE CHARGES.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE