

# PATIENT INFORMATION FORM

## PATIENT INFORMATION: (Please Circle) Minor Single Married Divorced Widowed

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_ Sex: M/F  
Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

## POLICY HOLDER INFORMATION: (If different from Patient) Single Married Divorced Widowed Separated

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_ Sex: M/F  
Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Address: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

## SPOUSE INFORMATION: (If different from above)

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_ Sex: M/F  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Address: \_\_\_\_\_ Home# \_\_\_\_\_ Cell #: \_\_\_\_\_

## GENERAL INFORMATION:

Family Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Nearest Relative(not living with you) \_\_\_\_\_ Phone: \_\_\_\_\_  
Incase of Emergency Notify: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

## INSURANCE INFORMATION:

Who referred you to our office? (Doctor/Friend/Phonebook) \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Insurance Plan: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group# \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary Insurance Plan: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone: \_\_\_\_\_

## HIPAA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at: [ ] Home [ ] Work [ ] Cell and May leave messages at: [ ] Home [ ] Work [ ] Cell.

I authorize the office to leave detailed messages about appointments/phone calls: [ ] YES [ ] NO

If you prefer us to leave messages with a specific individual please list them below:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

INDICATE ANY SPECIAL REQUESTS, IF ANY: \_\_\_\_\_

Patient (or Parent/Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

