

# PATIENT INFORMATION FORM

## PATIENT INFORMATION

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 (If different from Patient)

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. \_\_\_\_\_

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