PATIENT INFORMATION

When registering, please present proof of insurance.

24 hour notice is required for cancellations. Service fee may be applied if less than 24 hour notice is given.

Payment is expected at the time of service.

PLEASE PRINT

DATE:________/________/________ **TITLE: (Ms., Mrs., Mr., Miss, Dr.)_______________**

FIRST NAME:_________________________ **LAST NAME:___________________** **M.I._____**

ADDRESS: ____

CITY:____ ST:_______ ZIP:___________

BIRTH DATE:_________/_________/_________ **SOCIAL SECURITY #:______/______/_______**

HOME PHONE #: (_____) _______-__________ **WORK PHONE #: (_______) _______-________**

CELL PHONE #: (_______) _______-_____________ **PAGER #: (_______) _______-_____________**

E-MAIL ADDRESS: ____

MAY WE CALL TO CONFIRM YOUR FUTURE APPOINTMENTS? ☐ **YES** ☐ **NO**

WHAT IS THE BEST WAY TO REACH YOU? ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

SPOUSE/GUARDIAN: ____

RELATIONSHIP: ____________________________ **PHONE #: (_______) ________-_____________**

ADDRESS: ____

CITY:____ ST:_______ ZIP:___________

EMPLOYER: ____ **PHONE #:(_____) _______-_________**

PATIENT INFORMATION

RESPONSIBLE PARTY (if other than patient or guardian)___________________________________

ADDRESS:____

CITY:____ **ST:**_______ **ZIP:**___________

EMPLOYER: ___________________________________ **PHONE #:(**_____**)** _______-__________

SOCIAL SECURITY #:______/______/_______

EMERGENCY CONTACT:____

ADDRESS:____

CITY:____ **ST:**_______ **ZIP:**___________

PHONE #:(_______**)** _______-_____________

PATIENT'S EMPLOYER: ____

ADDRESS:____

CITY:____ **ST:**_______ **ZIP:**___________

PHONE #:(_______**)** _______-_____________

PAYMENT METHOD: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

MC/VISA/AMEX/DISCOVER #:____

EXPIRATION DATE: _______________________

PATIENT INFORMATION

INSURANCE COMPANY: ____

INSURANCE CO. ADDRESS: ____

CITY:____ **ST:**_______ **ZIP:**__________

PHONE #:(_______) _______-_____________ **POLICY #:**__________________________________

GROUP #: ______________________ **NAME OF INSURED:** ______________________________

INSURED'S ADDRESS: ____

CITY:____ **ST:**_______ **ZIP:**___________

DATE OF BIRTH: ______/______/_______ **PHONE #:**(_______) _______-_____________

INSURED'S SOCIAL SECURITY #: _________-_________-_______________

OTHER INSURANCE: ____

INSURANCE CO. ADDRESS: ____

CITY:____ **ST:**_______ **ZIP:**__________

PHONE #:(_______) _______-_____________ **POLICY #:**__________________________________

GROUP #: ______________________

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

SIGNATURE: ______________________________________ **DATE:** ___________________________