PATIENT INFORMATION AND CONSENT

Date:_____ Birth Date:_____

Name:_____Age:_____Sex_____Marital Status:_____
Last First Middle

Address_____Phone(____)____-_____
Apt. # City Zip

Social Security #_____Employer_____

Work Phone(___)____-_____ Cell Phone(___)____-_____ Email_____

Name of Emergency Contact_____Phone(____)_____-_____

Who can we thank for telling you about us?_____

If patient is a minor, name of parent bringing the child for treatment_____

INSURANCE

Name of the person who carries the insurance_____

Employer:_____ Social Security #_____

Address:_____Phone(____)____-_____

Name of Insurance Co._____

Address for claim Submission_____
_____

Phone _____

Group Number_____

Do You have secondary coverage?_____
If so, Name of Insured_____Relationship to you_____

Employer:_____Social Security #_____

Address:_____Phone( )_____-_____

Name of Insurance Co._____

Address for claim Submission_____

_____

_____

Phone (____)____-_____

Group Number_____