Patient Information

Name: ______________________________ SS#: ____________ Birth Date: __________

Address: ____

City: ________________________ State: ________ Zip: ______

Home Phone: ______________ Cell Phone: ____________ Work Phone: ______________

Spouses Name: ____________________________ Phone Number: ______________

Email Address: ________________________________

Can we confirm your appointment(s) via email? ☐ Yes ☐ No

Employer: ____

Employer's Address: ________________________ City: __________ State: ________

Phone Number: __________________

If patient is a child:

Father's Name: ____________________ Mother's Name: ______________________

Father's Phone: ____________________ Mother's Phone: ______________________

Person responsible for account: ____

In case of Emergency who do we contact?

Name: ______________________________ Phone Number: __________________

Name: ______________________________ Phone Number: __________________

INSURANCE INFORMATION

PRIMARY	SECONDARY
Name: ________________________	Name: ____________________________
SS#: ______________ Group #________	SS#: __________________ Group # ________
Ins. Co. ________________________	Ins. Co. ____________________________
Employer: ______________________	Employer: ____________________________

A copy of the Notice of Privacy Practices is available and can be provided upon my request. Initial: _________

Do you have a FLEX PLAN? ☐ Yes ☐ No

Financial Policy

We offer a **5% discount** if you pay your portion in full on the day services provided. **Initial:** _________

For your convenience we will bill your insurance company, however, you are responsible for the account. If an extended payment schedule is needed, please discuss this with the doctor.
Initial: ___________