PATIENT INFORMATION

Name: _____ **Today's date:** _____

Street: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone 1: _____ (W H M) **Phone 2:** _____ (W H M) **Sex:** M F

Email: _____ **SS#:** _____/_____/_____

Birth Date: _____ **Age:** _____ **Marital Status:** _____ **Pronouns:** _____

Occupation (now or before retirement): _____

Employer Name: _____ **Street:** _____ **ZIP:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____ (W H M)

GUARDIAN/PARTNER INFORMATION

Please provide documentation of power of attorney, if applicable.

Guardian/Partner's Name: _____ **Relationship:** _____

Phone: _____ (W H M) **SS#:** _____/_____/_____ **Birth Date**: _____ **Age:** _____

Street: _____ **City:** _____ **State:** _____ **ZIP:** _____

ACCOUNT INFORMATION

Name of person responsible for account: _____ **Relationship**: _____

Street: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone 1: _____ (W H M) **Phone 2:** _____ (W H M)

PRIMARY INSURANCE

Insurance Company	
Insurance Address	
ID# Group # Name	
Person Insured	
Birth Date	
SS #	
Employer & Contact info	

SECONDARY INSURANCE

Insurance Company	
Insurance Address	
ID# Group # Name	
Person Insured	
Birth Date	
SS #	
Employer & Contact info	

I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S). PAYMENT IS DUE IN FULL THE DAY SERVICE IS PROVIDED. THE PATIENT IS RESPONSIBLE FOR THE ACCOUNT EVEN IF THEY HAVE INSURANCE. I HAVE READ & UNDERSTOOD THE ABOVE INFORMATION & ANSWERED TO THE BEST OF MY ABILITY.

Signature: _____ **Date:** _____