

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.  
If you have questions, we'll be glad to help you.

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other  
Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  
Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other  
Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Employment Information

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone (Work): \_\_\_\_\_ Ext: \_\_\_\_\_

## Insurance Information

**Primary**  
Insurance Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Is Insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Patient's Relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

**Secondary**  
Insurance Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Is Insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Patient's Relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_