

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	
SEXUAL ORIENTATION		PREFERRED PRONOUN	GENDER IDENTITY					
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)				
ADDRESS				ADDRESS				
CITY, STATE ZIP				CITY, STATE ZIP				
WORK PHONE				WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED		SSN#	BIRTHDATE	GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

The above information is true to the best of my knowledge. I, the undersigned named patient hereby authorize the clinic and provider and whomever he/she may designate as his/her assistant to administer such treatment and perform such care as considered therapeutically necessary. I hereby certify that I have read and fully understand the authorization for Treatment/Care. I also certify that no guarantee or assurances have been made as to the results of treatment and care received.

SIGNATURE OF PATIENT/GUARDIAN

DATE