

**Patient Information**

Today's Date: \_\_\_\_\_

**About You**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
What you prefer to be called: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
\_\_\_\_ Minor \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_  
Spouse's name: \_\_\_\_\_ Number of Children: \_\_\_\_\_

**Account Information**

Person responsible for this account: \_\_\_\_\_ Relation: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Payment Method: \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_

\_\_\_\_\_ (initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

**In Case of Emergency**

Whom should we contact? \_\_\_\_\_ Relation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
Your medical doctor: \_\_\_\_\_ Phone: \_\_\_\_\_