Today's Date: ________________ ADULT

PATIENT INFORMATION (CONFIDENTIAL)

Name________________________________ Birthdate_____________ Home Phone________________

Email____ Cell Phone______________

Address_______________________________________City____________State_____ Zip____________

Social Security #__________________ Employer_______________________ Work Phone____________

Whom may we thank for referring you?____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? (Other than your home phone number)

Name______________________________________Relationship___________ Phone_______________

Name______________________________________Relationship___________ Phone_______________

INSURANCE INFORMATION

Primary Insurance

Subscriber Name____________________________Birthdate____________Reltionship to Patient______

Insurance Company____ Ins. Phone___________________

Subscriber ID#___________________ Group#____________________ (Please let us know if you need to add secondary insurance information.)

To the extent permitted under applicable law, I authorize release of any information relating to my insurance claims. I authorize the use of this signature on all insurance submissions.

Signed____ Date_____________________________