Welcome To Our Office **Today's Date** _____

Thank you for choosing our office. In order to serve you properly, we will need the following information.

First Name:	M.I.	Last Name	Birth date:	Sex: M F	Marital Status: S M W D
Street Address:			Home Phone #:		
City:	State:	Zip:	Work Phone #:		
Email address:			Cell Phone #:		
Social Security #:	D.L. #:				
Name of Employer:	Employer Address:		Occupation:		
For Patients under 18: Mother Full Name:	Father Full Name:				

Primary Insurance Company Name:	Subscriber # or ID #:	Group #:
Subscriber Name:	Is current insurance through your employer? Yes No	
Do you have a Secondary Insurance Company? Y N	Subscriber # or ID #:	Group#
Name of Spouse:	Subscriber Date of Birth:	Spouse Social Security #:
Name of Spouse's Employer:		Spouse's Work #:

Name of person financially responsible for this account:		Phone #:
In case of an Emergency, please contact:	Relationship to patient:	Phone #:
Who referred you to our office?	Primary Medical Doctor & phone#:	
Please state the reason for your visit today:		

By signing below, I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I also authorize this office to give me reasonable and proper medical care by today's standards. I assign and request payment of medical benefits directly to the physician for services rendered.

Patient, Parent or Guardian signature: _____ **Date:**_____