Welcome to Our Office

Please provide us with the following information

(please print)

General Information

Last Name ____ Jr. Sr. III IV

First Name _____________________________ Mr. Ms. Mrs. Miss. Dr.

Middle Initial _____

Preferred Name ________________________

Address____

City____________________________________ Zip Code ___________

State____

Birth Date _________________

Marital Status: S/M/D Employment: Employed/Retired/ Student

Gender (M/F) _____

Social Security Number _____________________________

Race: (circle) Black/White/Asian/American Indian/Hispanic/other

Language (if other than English)_______________________________

Contact Information

Home Phone________________ Work Phone______________ Ext______

Fax ___________________ Cell Phone__________________

Email________________________________

Preferred way to contact you? (circle one) Home Work Cell Email

Additional Information

Spouse's Name____

Spouse's Phone Number____

Whom may we thank for referring you?___________________________

Your Employer ____

Your Employer's Address_______________________________________

Family Physician:

Insurance Information

Primary Medical Insurance

Insurance Company:

Is the insurance under your name? Yes / No

If "No", whose name is it under?

Secondary Medical Insurance

Insurance Company:

Is the insurance under your name? Yes / No

If "No", whose name is it under?

Vision Insurance Plan

Insurance Company:

Is the insurance under your name? Yes / No

If "No", whose name is it under?

(We need to make a copy of your Insurance Card/s)

Billing Information

Person Responsible for Payment: (If other than Patient)

Last Name________________________ Mr. Ms. Mrs. Miss Dr

First Name______________________________ MI_____

Address____

City________________________State_____ Zip____________

Birth Date____________________

Home Phone____

Work Phone____

Employer____

Patient Relation: (circle one) spouse child other