Patient Demographics:

Last Name: ____ First Name: ________________________MI: _________

DOB: _____/_____/_________ Gender: __________________ SSN:________-______-__________

Are you enrolled in school? **Yes/No** Full-Time Student ___ Part-Time Student ____

Do you smoke? **Yes/No** How often per day? ________________ Religion :_______________________(optional)

How did you hear about us? ____

Physical Address: ____

City: _____________________________________ State: ____________________ Zip: __________________

Mailing Address (If different from above):____

City: _____________________________________ State: ____________________ Zip: __________________

Home Phone: (____)_____-______ Cell Phone: (____)_____-______ Preferred Phone: **Home Cell DO NOT CALL**

E-mail: ____

Insurance:
Primary Insurance Provider _____________________________________
Subscriber ID: _______________________ Group/Plan No: ________________ Co-payment Amount: _________________
Do you have a Secondary Insurance? **Yes/No** Secondary Provider: ____

Financially Responsible Contact: (Primary Insured Party, If Different Than Patient)
Name: _______________________________ DOB: ________________ Relationship to Patient: ________________________
Address Line 1:____
City:_______________________________State:_______________________Zip: ________________________
Home Phone: (____)____-_________Cell Phone: (____)_____-_________Work Phone: (____)_____-_________
Emergency Contacts:

Name: _____________________________________ Relationship to Patient: _______________________________________

Home Phone: (________)______-_______ Cell: (_________)______-_______ Work: (_______)______-_______

Patient Authorization for Treatment: __________________________________ Date: ________________
Parent or Guardian: ____ Date: ______________

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