

# PATIENT INFORMATION

Dear Patient:

Please complete all sections of this questionnaire; **all sections are required.** Your answers help us to ensure that you get the best care that we can provide. **THANK YOU.**

## PERSONAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Marital Status: M S D W Spouse \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## INSURANCE INFORMATION

In order for us to process your insurance claims properly and in a timely fashion please complete the information below. If you have your insurance card with you, we will copy it for our files. Please print neatly and legibly. Thank you.

### PRIMARY INSURANCE SUBSCRIBER & CARRIER:

Name of Primary Insured: \_\_\_\_\_ Primary's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Primary's Social Security #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary's Employer Name & Address: \_\_\_\_\_

### SECONDARY INSURANCE SUBSCRIBER & CARRIER

Name of Primary Insured: \_\_\_\_\_ Primary's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Primary's Social Security #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary's Employer Name & Address: \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_