

P A T I E N T	Patient Name:			Today's date:					
	FIRST	MIDDLE INITIAL	LAST	<input type="checkbox"/> Male	<input type="checkbox"/> Female				
	Mailing address:			Home Phone: ()					
	City, State, Zip:			Work Phone: ()					
	Physical address:			Date of Birth:					
	Employer:			SSN:					
	Status (Circle One):			Single	Separated	Widowed	Married	Divorced	Dependent Child
Primary Care Physician:									
E M E R G E N C Y	Next of kin / Emergency contact: In the event of an emergency, we may need to contact a family member or close friend on your behalf. Please provide a name and phone number for these purposes. NOTE: If the patient is a dependent child, please indicate a parent's name and phone numbers.								
	Name:			Relationship:					
	Address:			Home Phone: ()					
	City, State, Zip:			Work Phone: ()					
	Person Responsible for Account: Please complete this section if someone other than the patient is financially responsible for this account (e.g., parent, non-custodial parent, spouse, etc.)								
A C C O U N T	Billing Name:			Relationship:					
	FIRST	MIDDLE INITIAL	LAST						
	Address (if different than above):			Home Phone: ()					
	City, State, Zip:			Work Phone: ()					
I N S U R A N C E	Primary Insurance Coverage: *A COPY OF YOUR ID CARD IS REQUIRED TO BILL YOUR INSURANCE *								
	NOTE: If you do not have medical insurance, indicate "PRIVATE" below.								
	Insurance Company:								
	Policyholder's name:			Policyholder's birthdate:					
	Employer:			Copayment amount:					
	Group number:			Effective date:					
	ID#:								
	Secondary Insurance Coverage:								
	Insurance Company:								
	Policyholder's name:			Policyholder's birthdate:					
	Employer:			Copayment amount:					
Group number:			Effective date:						
ID#:									