WELCOME TO OUR OFFICE

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone (____) _____ Cell Phone (____) _____ Email_____

Age_____ D.O.B._____ Last 4 digits of S.S. # XXX-XX-_____

Type of Work_____ Student_____ Full Time_____ Part Time_____

Employed By_____ Business Phone_____

Address_____ Spouse Name_____

Spouse Employer_____ Business Phone_____

(If applicable)

Insurance #1_____ Insurance #2_____

Address_____ Address_____

_____ _____

Group Name_____ Group Name_____

Policy Number_____ Policy Number_____

Name of Insured_____ Name of Insured_____

Insured D.O.B._____ Insured D.O.B._____

Insured S.S.N._____ Insured S.S.N._____

Other Insurance_____ Medical Doctor_____Date of last visit_____

In case of EMERGENCY, whom should be notified?_____ Phone_____

Whom may we thank for referring you?_____

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services. I hereby give my permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

Signature_____ Date_____