

**PATIENT INFORMATION**

**Patient Name** (First,Middle,Last): \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home Phone #:( )** \_\_\_\_\_ **Cell #: ( )** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Work #: ( )** \_\_\_\_\_  
**Primary Care Physician:** \_\_\_\_\_  
**Emergency Contact Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
**Sex:**  Male  Female    **Marital Status:**  Single  Married  Divorced  Widowed  Separated  
**How did you hear about us?**  
 Drive By    Referral \_\_\_\_\_    Newspaper    TV    Flyer    Other \_\_\_\_\_

**Minors Only**

**Mother's Name** (First,Middle,Last): \_\_\_\_\_ **SS #:** \_\_\_\_\_  
**Mother's Employer:** \_\_\_\_\_ **Phone #: ( )** \_\_\_\_\_  
**Father's Name** (First,Middle,Last): \_\_\_\_\_ **SS #:** \_\_\_\_\_  
**Father's Employer:** \_\_\_\_\_ **Phone #: ( )** \_\_\_\_\_

**Insured Name** (First,Middle,Last): \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Relation to Patient:** \_\_\_\_\_  
**Home Phone #:( )** \_\_\_\_\_ **Cell #: ( )** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Work #: ( )** \_\_\_\_\_  
**Primary Insurance Name:** \_\_\_\_\_  
**Member/Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**Secondary Insurance Name:** \_\_\_\_\_  
**Member/Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Relation to Patient:** \_\_\_\_\_

I have read and understand the medical treatment and financial agreement and agree to follow the terms as provided within. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am duly authorized to act on behalf of the patient and to sign this agreement.

**(See Medical Treatment and Financial Agreement attached to clipboard)**

**Patient/Guardian Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_