PATIENT INFORMATION:

Last Name: ______________________ First Name: ______________________

Preferred to be called: __________ Date of Birth: ______________________ Sex: M F

Mailing Address: ______________________ City, State, Zip: ______________________

Cell Phone: ______________ Work Phone: ______________ Home Phone: ______________

E-mail Address: ______________________

SS#: ______________ Occupation: ______________

Employer: ______________________ Address, City State, Zip ______________________

Emergency Contact Name: ______________________ Phone # : ______________

Spouse's Name: ______________________ Occupation: ______________________

Spouse's Address (if different than above): ______________________ City, State, Zip: ______________

Spouse's Employer: ______________________ Address, City, State, Zip: ______________________

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: ______________________ **Place** ______________ **Time:** __________

How did you hear about our office? Please check:
_____Internet Search ____Patient referral ____Website ____Radio Ad ____Yellow Pages Other ________

INSURANCE INFORMATION:

Medical Insurance Company: ______________________ Address: ______________________

City: ______________ State: __________ Zip: __________ Phone: ______________

Subscribers Name ______________________ Relationship to patient: ______________

DOB: ______________ Subscriber's SSN# ______________________

ID#/Policy#: ______________________ Group#: ______________________

Dental Insurance Company : ______________________ Address: ______________________

City: ______________ State: __________ Zip: __________ Phone #: ______________

Subscriber's Name: ______________________ Relationship to patient: ______________

DOB: ______________ Subscriber's SSN#: ______________

ID#/ Policy # ______________________ Group#: ______________________

Notice of Privacy Practices(below)
Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

______________________ Date: ______________

Signature of Patient