PATIENT INFORMATION FORM

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Name:______________________________Nickname:__________________DOB:__________________________
Address:__________________________________City: __________________ State:__________Zip:___________
Home Phone:_____________________________ Cell Phone:_____________________________
Email (for appointment reminder):___________________________________ Sex: Male or Female
Name of school patient attends:_____________________________________
Whom may we thank for referring you?:____
Does your child have siblings?:_________________ If so, names & ages:__________________________________

Responsible Party

Name of person responsible for this patient:_________________________Relationship to patient:_____________
Address (if different from above):_______________ City: __________________
State:__________Zip:________ Home phone:_______________________________ Cell Phone:____
Birth Date:___________________ Social Security:______________________
Email Address:____Marital Status:_______________

Insurance Information

Name of Insured:_____________________________________ Relationship to patient:_____________________
Birthdate:_____________________Social Security:___________________Date Employed:_________________
Insured Party's Address:_______________________________City:______________State:____Zip:___________ Name of employer:____________________________Occupation:______________Work Phone:_____________
Insurance Co:______________________Tel #:_____________Group#:____________Policy/ID#:____________
Amount of your Deductible:___________________________Max Annual Benefit:________________________
Do you have any additional insurance?: (circle one) YES NO If yes, complete the following:
Name of insured:__________________Soc. Security #:_________________Date Employed:________________
Name of Employer:___________________Union or local#:_______________Work phone:_________________
Employer address:___________________________________City:______________State:_____Zip:__________
Insurance Co.______________________Tel#:_____________Group #:____________Policy/ID#:____________
Insurance Co Address:___________________________City:__________________State:_____Zip:__________
Amount of your Deductible:_________How much have you used?:_________Max Annual Benefit____________

In my absence, I give permission to:___________________________to accompany my child and consent for any needed treatment.

You agree that by checking the Electronic Signature such action will constitute your electric signature having the same legal force and effect as a hand written signature

Signature of patient (or parent, if minor) ____