PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____ Patient Name_____

SS #/SIN_____ ☐ Male ☐ Female Birthdate_____

Hand Dominance ☐ ***Right*** ☐ ***Left***

E-Mail_____

Address_____City_____State/Prov._____Zip/P.C._____

Home Phone_____Cell Phone_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or patient/guardian's employer_____Work phone_____
Business address_____City_____State/Prov._____Zip/P.C._____
Spouse or parent/guardian's name_____Employer_____Work phone_____
If patient is a student, name of school/college_____City_____State/Prov._____

Whom may we thank for referring you?_____
Person to contact in case of emergency_____Phone_____

Responsible Party/ Insurance Information

Name of person responsible/insured for this account_____
Relationship to patient_____
Address_____Home phone_____
E-Mail_____Cell phone_____
Birthdate_____ Driver's license #/SS#_____
Employer_____Work phone_____
Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance company_____Contract/ID #_____Group#_____
Ins. Co. address_____City_____State/Prov._____Zip/P.C._____
How much is your deductible?_____How much have you used?_____ Max. annual benefit?_____
Copayment?_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured_____Relationship to patient_____
Birthdate_____SS #/SIN_____Date employed_____
Name of employer_____Work phone_____
Address of employer_____City_____State/Prov._____Zip/P.C._____
Ins. Co. address_____City_____State/Prov._____Zip/P.C._____
How much is you deductible?_____ How much have you used?_____ Max. annual benefit?_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____

Signature of patient or parent/guardian if minor Date