

Patient # \_\_\_\_\_  
 SS# / SIN \_\_\_\_\_  
 Date \_\_\_\_\_

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Which of the following communications would you accept? (Check all that apply)  Email  Text  Phone  
 Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
 If Student, Name of School/College \_\_\_\_\_ City/State/Zip \_\_\_\_\_  F/T  P/T  
 Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party (if different from above)

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# / SIN \_\_\_\_\_  
 Is this person currently a patient in our office?  Yes  No

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**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 \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_