PATIENT INFORMATION

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Last Name	First Name		Middle Initial	Preferred Name
Social Security Number	Date of Birth	Cell Phone #		Home Phone #

Preferred Contact Method ☐ Text Message ☐ Phone Call to Cell ☐ Phone Call to Home

Email Address

Street Address		City		State	Zip Code

☐ Male ☐ Female   ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Child (under 12)

Is the patient a minor? ☐ Yes ☐ No | Name of Responsible Party | Relationship to Patient

PRIMARY INSURANCE

Subscriber: _____

Sub DOB: _____

Sub SSN: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

SECONDARY INSURANCE (if applicable)

Subscriber: _____

Sub DOB: _____

Sub SSN: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

EMPLOYER

Name: _____

Address: _____

City, State Zip: _____

Occupation: _____

Phone: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

May we share personal medical information? ☐ Yes ☐ No

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you in the back of this packet.

Patient / Guardian Signature	*(If guardian, write name please)*	Date

Rev 01/2026