

**DATE of Appointment:** \_\_\_\_\_ / **Dr.** \_\_\_\_\_  
**If applicable, please allow us to copy your insurance card**

**PATIENT INFORMATION**

Patient's Name (LAST, FIRST & MIDDLE INT.)			
Street Address (Apartment #)		Referring Doctor and Phone Number:	
City, State		Zip Code	
Birth Date	Age	Gender	SS# (Must have to put in our database)
Patient's Employer or Specify if patient is a student; full or part time		Occupation	
Home Phone Number	Work Phone Number	Mobile Phone Number	E-MAIL ADDRESS
Emergency Notification Name & Phone #			Relationship
Husband's Or Wife's FULL Name		Husband's or Wife's Date of Birth	SS#
Husband's Or Wife's Employer		Employer's Street Address	
City, State Zip Code		Business Phone No	

**IF THE PATIENT IS A MINOR OR STUDENT: FULL TIME STUDENT: YES OR NO**  
**List GRADE LEVEL** \_\_\_\_\_

Mother's Name	SS No	Date Of Birth
Mother's Employer		Business Phone
Father's Name	SS No	Date Of Birth
Father's Employer		Business Phone

**SIGNATURE OF**  
**Parent or Guardian's authorization to treat a minor :**

1. I give my permission to release part or all of my medical records including photographs upon request to Insurance carrier(s).
2. I authorize payment of medical benefits to the Doctor.
3. **I accept responsibility for payment of any balance not covered by my Insurance. I understand**

that I am responsible to call my Insurance Company to assure the Dr. is covered by my Insurance plan.

**PLEASE SIGN**

**HERE:** \_\_\_\_\_