

**Welcome To Our Office**

New Patient Information

Date \_\_\_\_\_

PATIENT'S NAME (PLEASE PRINT) (FULL NAME)		S.S.#	AGE	SEX	DOB
				M	
STREET ADDRESS		CITY AND STATE			ZIP
HOME PHONE	CELL PHONE	E-MAIL			MARITAL STATUS
					S    M    W    D
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)			BUS. PHONE      EXT
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP
CONTACT PERSON'S NAME IN CASE OF EMERGENCY		PHONE			

SPOUSE OR PARENT'S NAME	SPOUSE OR PARENT'S NAME S.S.#	BIRTHDATE
SPOUSE OR PARENT'S EMPLOYERS	EMPLOYER'S STREET ADDRESS	BUS. PHONE      EXT
SPOUSE'S STREET ADDRESS	CITY AND STATE	ZIP

NAME AND ADDRESS OF REFERRING PHYSICIAN	NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN (FAMILY DR.)
---	---

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE
--------------------------------	-----------------------------	-----	------------

PRIMARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
POLICYHOLDER'S NAME	POLICYHOLDER'S BIRTHDATE	
SECONDARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
SECONDARY INS. POLICYHOLDER'S NAME	SECONDARY INS. POLICYHOLDER'S BIRTHDATE	

WHAT ARE YOU SEEING THE DOCTOR FOR TODAY?	DATE OF ONSET	DESCRIPTION OF PROBLEM OR INJURY
IF THIS IS A WORK RELATED INJURY (PLEASE FILL OUT THIS SECTION)		BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED
NAME OF EMPLOYMENT WHERE INJURY HAPPENED?		COMPLETE ADDRESS OF THAT EMPLOYER
WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO    STATE _____	DATE OF ACCIDENT	NAME OF ATTORNEY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES AND COPAYMENTS REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE PERSONNEL.

**VERY IMPORTANT:**  
**PLEASE BRING INSURANCE CARDS, XRAY'S, MRI AND ANY OFFICE NOTES RELATING TO TODAY'S VISIT.**