WELCOME TO OUR OFFICE

TODAY'S DATE

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

Client's Name   Birthdate   Marital Status

Residence address   City   State   Zip   Home Phone

If child, parent's or guardian's name   Birthdate

Name of employer   Address   Business Phone

Social Security Number   Drivers License   Occupation

Do you have medical insurance?   [ ]Yes [ ]No   Insurance Company Name & Address

Insured's name   Policy number   Group Number

Birthdate   Social Security Number   Name of Spouse

Is there secondary Ins Spouse 2nd carrier, etc.   [ ]Yes [ ]No   Name & Address of Spouse Employer   Business Phone

Secondary insurance name & address   Policy number   Group number

Workman's Compensation   Name of Company

Address of company   Company phone   Treatment Authorized by

Person financially responsible for this account   Address

Whom may we thank for referring you?   Address

I authorize this office to release any information necessary to expedite insurance claims.
I understand that I am responsible for expenses incurred.

Patient, Parent or Guardian signature   Date