



**PATIENT INFORMATION**

Patient Name (Last)		(First)		(MI)	Social Security Number		
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.							
Home Address: Street				Apt. No.	City		
State	Zip Code	Home Phone ( )		Birth Date		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
E-Mail Address		Patient/Family preferred method of communication		Employer Name and Address			
Ethnic Group <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian and Other Pacific Islander <input type="checkbox"/> Other race please print: _____ <input type="checkbox"/> Two or more race please print: _____							
Language/Preference (if other than English)		Do you have a hearing or vision impairment requiring assistance for effective communication? If yes, check appropriate boxes. <input type="checkbox"/> Vision <input type="checkbox"/> Hearing			Legal Guardian		
Please Print					Relationship to patient / name (Please Print)		

**PARENT / GUARANTOR**

<b>(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)</b>							
Patient's Relationship to Guarantor: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____							
Guarantor Name					Social Security Number		
Home Address: Street				Apt. No.	City		
State	Zip Code	Home Phone ( )		Work Phone ( )			
Cell Phone ( )	Alternate Phone ( )		Would You Like to Receive Information by E-Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, E-Mail Address?	
Employer Name and Address							
Other Parent					Social Security Number		
Employer Name and Address			Home Phone ( )	Work Phone ( )	Cell Phone ( )		

**INSURANCE INFORMATION**

<b>PRIMARY MEDICAL INSURANCE COMPANY</b>							
Insurance ID No. (Member/Certificate)		Plan Name		Plan No.	Group No.		
Subscriber Name <small>(The primary name in which The insurance policy is held)</small>					Effective Date		
Social Security Number		Subscriber D.O.B.		Patient's Relationship to Subscriber <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____			
<b>SECONDARY MEDICAL INSURANCE COMPANY</b>							
Insurance ID No. (Member/Certificate)		Plan Name		Plan No.	Group No.		
Subscriber Name					Effective Date		
Social Security Number		Subscriber D.O.B.		Patient's Relationship to Subscriber <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____			

**IN CASE OF EMERGENCY PLEASE CONTACT:**

Name	Relationship	Phone Number
------	--------------	--------------