

# PATIENT INFORMATION

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

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Patient # \_\_\_\_\_  
SS #/SIN \_\_\_\_\_  Male  Female Birthdate \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell phone \_\_\_\_\_  
Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated  
Patient's or parent/guardian's employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Spouse or parent/guardian's name \_\_\_\_\_ Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
If patient is a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ Home phone \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell phone \_\_\_\_\_  
Driver's license # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Is this person currently a patient at our office?  Yes  No

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS #/SIN \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Address of employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Union or local # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

Do you have any additional insurance?  Yes  No If yes, complete the following:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS #/SIN \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Address of employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Union or local # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor

\_\_\_\_\_ Date