

## Demographic and Insurance Information

Patient Name: \_\_\_\_\_ Are you a minor: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security#: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_ Male or Female \_\_\_

Marital Status: \_ Single \_ Married \_ Widowed \_ Divorced Ethnicity: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer Name/Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Copay: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Copay: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

X \_\_\_\_\_  
Signature of Patient or Responsible Party

X \_\_\_\_\_  
Date