



# PATIENT INFORMATION SHEET

Preferred Method(s) of Contact:	E-mail	Home Phone	Work Phone	Cell Phone
Best Time of Day:	Daytime	Evening		

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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

E-mail Address (1): \_\_\_\_\_ E-mail Address (2): \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you find us? \_\_\_\_\_

## EMPLOYMENT

	Full-Time	Part-Time	Retired	Unemployed
Employer:				
Employer's Address:		Occupation:		
		City:	State:	Zip:
Spouse/Partner Employer:		Occupation:		
Employer's Address:		City:	State:	Zip:

## SCHOOLING (if currently enrolled)

School Name: \_\_\_\_\_ Grade/Year: \_\_\_\_\_ Studying: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Social Security#: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Social Security#: \_\_\_\_\_ DOB: \_\_\_\_\_

Must present valid insurance card and photo ID to front desk.

On your first visit to the office, you will be asked to sign acknowledgement of our office forms & policies.