

Patient Information as of \_\_\_\_\_ (enter today's date)  
 (Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name**

\_\_\_\_\_ First Middle Last

Address \_\_\_\_\_  
 Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Restrictions: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Gender  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Patient's Employer**

Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_  
 Street & Suite # City State Zip

**How did you hear about ?**

(Mark all that apply)

TV News  TV Ad  Phone Book  Magazine  Newsletter  Seminar  Salon  Web

Friend/Relative: \_\_\_\_\_  Doctor: \_\_\_\_\_  Other: \_\_\_\_\_

If you were referred by a specific person, may we thank them?  Yes  No

**Emergency Contact**

(Not in your household)

Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

**Primary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between and myself.

**Signature**

**Date**

\_\_\_\_\_