

PATIENT INFORMATION SHEET

Full Name:		DOB: / /	
Mailing Address:			
City:		State:	Zip:
Home Phone: ()		Cell Phone: ()	
Email Address:			
Employer:		Work Phone: ()	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		Spouse's Name:	
How did you hear about our clinic?			
Who is your Primary Care Provider?			
<i>If different than the patient, NOT an insurance company</i>			
Person Responsible for Payment		Relationship:	
Emergency Contact:			
Phone: ()		Relationship:	

**THIS SECTION MUST BE FILLED OUT
 IN ORDER FOR US TO FILE YOUR INSURANCE(S)**

Primary Insurance: YES NO SELF-PAY Secondary Insurance: YES NO
(Provide physical card to patient care coordinator)

I certify that the above information is true and correct to the best of my knowledge. Also, by signing below I am giving permission to leave messages about appointments and/or medical reports at the personal address, personal phone number, email address and/or spouse or responsible party contact information. (Mark out any that should not be included.)

I understand that I am financially responsible for all charges, regardless of insurance coverage.

Signature of Patient / Authorized Representative

Date