Today's Date _____

Referred By _____

Patient Name (First, Middle, Last) _____ Date of Birth ___/___/____

Street Address _____ Sex ☐Male ☐ Female ☐Trans

City _____ State _____ Zip _____Status ☐Single ☐ Married ☐ Divorced ☐ Widow

Preferred Phone No. _____ Alt. Phone No. _____Email_____

Complete this section if Responsible Party for Billing is different from above. Billing Name_____

Billing Phone No. _____ Billing Email _____ Relationship to Patient_____

Billing Street Address _____ City _____ State _____ Zip_____

Insurance _____Policy No. _____Group No._____

Insurance Address _____City _____ State _____ Zip _____

Insurance Phone No._____

Policy Holder Name _____ Policy Holder Date of Birth ___/___/____

Policy Holder Address _____City _____ State _____ Zip_____

Policy Holder Employer _____ Relationship to Policy Holder_____

2ND Insurance _____Policy No. _____Group No._____

2ND Insurance Address _____ City _____ State _____ Zip _____

2ND Insurance Phone No._____

Policy Holder Name _____ Policy Holder Date of Birth ___/___/____

Policy Holder Address _____City _____ State _____ Zip_____

Policy Holder Employer _____ Relationship to Policy Holder_____

Emergency Contact (required) _____ Phone No._____ Relationship_____

Primary Care Physician _____ Clinic_____ Phone _____

Address _____ City _____ State _____ Zip _____

☐ I consent to release my health records to my primary care physician.

_____ _____

Patient Signature Date

_____ _____ _____

Parent/Legal Guardian Signature (if patient under age 18) Date Name