

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Date _____ Patient name _____ Patient # _____
FIRST MI LAST
SS#/SIN _____ Male Female Birthdate _____ Home phone _____
Address _____ City _____ State/ Zip/
Prov. P.C. _____
Email _____ Cell phone _____
Check appropriate box: Minor Single Married Separated Divorced Widowed
Patient or parent/guardian's employer _____ Work phone _____
Business address _____ City _____ State/ Zip/
Prov. P.C. _____
Spouse or parent/guardian's name _____ Employer _____ Work phone _____
If patient is a student, name of school/college _____ City _____ State/ Prov. _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Email _____ Cell phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____
Is this person currently a patient in our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/ Zip/
Prov. P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Insurance co. address _____ City _____ State/ Zip/
Prov. P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? Yes No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/ Zip/
Prov. P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Insurance co. address _____ City _____ State/ Zip/
Prov. P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X

Signature of patient (or parent/guardian if minor)

Date