

## Patient Information Form

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Name: \_\_\_\_\_ Hm Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Spouse's Cell Phone: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Phone \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Dentist: \_\_\_\_\_ Phone \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Whom may we contact in the case of an emergency?

\_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us?

\_\_\_\_\_ Phone: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

I will be paying today by cash: \_\_\_\_ check: \_\_\_\_ credit card: \_\_\_\_\_

*I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent (if minor) Date