Patient Information ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ___/___/___

Name _____
Last *First* *M.I.*

Date of Birth: ___/___/___ Age: _____ Gender: ☐ Male ☐ Female

Race/Ethnicity (*optional*): ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐Hispanic or Latino ☐ White

ADDRESS:

Mailing Address _____
City *State* *Zip Code*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____Date of Birth: ___/___/___
Last *First* *M.I.*

Address:_____
City *State* *Zip Code*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:_____

Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other_____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____

Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other_____

Please present your insurance card(s) and a photo ID
to the receptionist along with this completed form. Thank you.