PATIENT INFORMATION SHEET

Date:_____

Patient's Name:_____ **SSN:**_____ **Birthdate:**_____ **Age:**

Address: _____ **C/S/Z:**_____

Phone #:_____ **Sex: M F Marital Status: M S W D No. of Dependents:**

Employer:_____ **Phone:**_____ **Occupation:**_____

Spouse:_____ **SSN:**_____ **Occupation :**_____

Employer:_____ **Phone:**_____

Emergency Contact Person:_____ **Relationship:**_____

Address:_____ **Phone:**_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:_____ **Relationship:**_____

Residence Address:_____ **C/S/Z:**_____

Hm. Phone #:_____ **SSN:**_____

Employer: _____ **# of Years Employed:**

Employer's Address:_____ **C/S/Z:**

Union Local No.:_____ **Wk. Phone #:**_____ **Dental Insurance:**_____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE (Use your Identification Card)

Insured's Name:_____ **SSN:**_____

Patient's Relationship to Insured: Self:_____ **Spouse:**_____**Child:**_____**Other:**_____

Employer:_____ **Phone #:**_____ **Union Local:**_____

Insurance Company:_____ **Group # :**_____

Claims address:_____

SECONDARY INSURANCE (Use your Identification Card)

Insured's Name:_____ **SSN:**_____

Patient's Relationship to Insured: Self:_____ **Spouse:**_____ **Child:**_____**Other:**_____

Employer:_____ **Phone #:**_____ **Union Local:**_____

Insurance Company:_____ **Group # :**_____

Claims address:_____