Patient Information

Patient Legal Name (First, Middle, Last):_____

DOB: _____ Sex:_____ SSN: _____

Phone Number: _____ Email address: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____

Employer Phone Number: _____

Marital Status: _____ Spouse's Name: _____

Are you a dependent? YES ☐ NO ☐

If yes, Guardian's Name: _____

Guardian's Relationship: _____ Phone:_____

Emergency Contact Information

Emergency Contact 1 : _____

Relationship: _____ Phone Number: _____

Emergency Contact 2 : _____

Relationship: _____ Phone Number: _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct and understand that failure to provide such information will result as a self-pay visit and will be my financial responsibility.

Patient: _____ Date: _____