



CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: (Last Name) / (First Name) / (Middle Initial)

Preferred Name: Age: Date of Birth: S.S.#:

Address: (street#/PO Box) / (city) / (state) / (Zip code)

Telephone # () / () / () (home) (work) (cell phone or other)

E-mail address: Gender: female ___ male ___

Are you (check one): Single ___ Married ___ Other ___ Partner's Name:

Occupation: (circle) Full time/ Part time /Student/ Retired

Employer / School:

Address: (Street / PO Box) / (City) / (State) / (Zip code)

How did you hear about our clinic?

Emergency Contact (Name) (Relationship) () (Day Phone) () (Evening Phone)

What is the best way to communicate with you between office visits? (E-mail, Home, Work, Cell Phone). Is there any place you do NOT want us to leave a message?

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May we send you educational/promotional materials such as newsletters via e-mail? Yes No
May our practitioner(s) discuss your private medical information with you via e-mail? Yes No

Insurance Information - Please provide copy of front and back of Insurance card.

Group Insurance: Insurance Co:

Insured Full Legal Name: Date of Birth: ___/___/___

Insured's Address: (street / PO Box) / (City) / (State) / (Zip Code) / () (Phone Number)

MVA: Date of MVA: State MVA occurred: Claim number:

Insurance Co: Claim submitted Y N Adjuster: Phone: ()

Attorney's Name: Phone: () PIP Coverage:

Worker's comp: Please fill out additional form.

Medicare: Please fill out additional form.

Do you have any secondary or additional Insurance plans? Yes No Name:

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient Today's Date