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## WELCOME!

### Patient: PLEASE PRINT

Name(First)\_\_\_\_\_ (M.I.)\_\_\_\_\_ (Last)\_\_\_\_\_

Gender: M F Birthdate \_\_\_/\_\_\_/\_\_\_ Age:\_\_\_\_\_ SS#\_\_\_\_\_

Are you:  Single  Married  Domestic Partner

Do you have kids?  No  Yes Names and ages:\_\_\_\_\_

Home Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ Cell Phone\_\_\_\_\_

Work Phone\_\_\_\_\_ Ext.\_\_\_\_\_

E-mail Address \_\_\_\_\_

Employer Name\_\_\_\_\_ Occupation\_\_\_\_\_

Job Functions / Work Environment \_\_\_\_\_

Employer Address\_\_\_\_\_

Whom may we THANK for referring you to us?\_\_\_\_\_

### Spouse, Guardian or Partner (if applicable):

Name\_\_\_\_\_

Employer Name\_\_\_\_\_ Work Phone\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Occupation \_\_\_\_\_

### Emergency: (Name and address of nearest relative or friend **not living with you**)

Name\_\_\_\_\_ Relation to Patient\_\_\_\_\_

Home Phone\_\_\_\_\_ Work phone\_\_\_\_\_

Address\_\_\_\_\_

### My Account Will Be Handled By:

Self Pay – We do not accept assignment so you may send your receipts to your health insurance company for reimbursement.  Work Comp.  Personal Injury  Medicare

### Responsible Party: (Complete this section if you are not the patient but are responsible for the bill, such as parent or guardian)

Responsible Person\_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address\_\_\_\_\_ Apt #\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ Work Phone\_\_\_\_\_

Employer Name\_\_\_\_\_ Occupation\_\_\_\_\_