NAME OF PATIENT_____ DATE_____
First Last Middle

DATE OF BIRTH_____ AGE___ GENDER_____SSN_____MARITAL STATUS_____

MAILING ADDRESS_____
Street/PO BOX Apt# City State Zip

_____ YES ☐ NO ☐ _____
PRIMARY TELEPHONE NO OK to Leave a Detailed Message EMAIL AD DRESS:

PATIENT'S OCCUPATION_____ EMPLOYER_____

EMERGENCY CONTACT_____
Name Relationship Phone Number

FINANCIALLY RESPONSIBLE PARTY INFORMATION

☐ *SELF - **OR** - Complete if someone other than the patient is responsible for the bill*

NAME_____DATE OF BIRTH _____SSN_____
MAILING ADDRESS_____
Street/PO BOX Apt# City State Zip

Phone number_____ Email Address _____

MEDICAL INSURANCE INFORMATION

Complete only if you are NOT the subscriber of your health insurance

Subscriber Name_____ Date of Birth_____
Relationship to subscriber_____

PERMISSION TO SHARE PROTECTED HEALTH INFORMATION (PHI)

I give permission for my PHI to be shared or discussed with the following persons:

Name_____Relationship_____
Name_____Relationship_____

Signature_____Date:_____