Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient name _____ (FIRST / MI / LAST) Patient # _____

SS#/SIN _____ ☐ Male ☐ Female Birthdate _____ Home phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or parent/guardian's employer _____ Work phone _____

Business address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or parent/guardian's name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State/Prov. _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Email _____ Cell Phone _____

Driver's license # _____ Birthdate _____ Financial institution _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Insurance co. address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Insurance co. address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

Signature of patient (or parent/guardian if minor) Date

ITEM 07-0773325/17634 © 1998 COLWELL 1.800.637.1140