



PATIENT INFORMATION						
Patient Name (Last)		(First)		(MI)	Social Security Number	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.						
Birth Date		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Home Address: Street				Apt. No.	City	
State	Zip Code	Home Phone ( )	Work Phone ( )	Alternate Phone ( )	Cell Phone ( )	
E-Mail Address		Patient/Family preferred method of communication		Employer Name and Address		
Ethnic Group <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian and Other Pacific Islander <input type="checkbox"/> Other race please print: _____ <input type="checkbox"/> Two or more race please print: _____						
Language/Preference (if other than English)		Do you have a hearing or vision impairment requiring assistance for effective communication? If yes, check appropriate boxes. <input type="checkbox"/> Vision <input type="checkbox"/> Hearing		Legal Guardian		
Please Print				Relationship to patient / name (Please Print)		
GUARANTOR INFORMATION						
<b>(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)</b>						
Please Check Box to Indicate if Information is Same as Patient				<input type="checkbox"/> Same as Patient		
Guarantor Name					Social Security Number	
Patient's Relationship to Guarantor: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Student <input type="checkbox"/> Other _____						
Home Address: Street				Apt. No.	City	
State	Zip Code	Home Phone ( )	Work Phone ( )			
Employer Name and Address						
INSURANCE INFORMATION						
PRIMARY MEDICAL INSURANCE COMPANY						
Insurance ID No. (Member/Certificate)		Plan Name		Plan No.	Group No.	
Subscriber Name <small>(The primary name in which the insurance policy is held)</small>				Effective Date		
Social Security Number		Subscriber D.O.B.				
Patient's Relationship to Guarantor: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Student <input type="checkbox"/> Other _____						
SECONDARY MEDICAL INSURANCE COMPANY						
Insurance ID No. (Member/Certificate)		Plan Name		Plan No.	Group No.	
Subscriber Name				Effective Date		
Social Security Number		Subscriber D.O.B.				
Patient's Relationship to Guarantor: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Student <input type="checkbox"/> Other _____						
IN CASE OF EMERGENCY PLEASE CONTACT:						
Name				Phone Number		