PATIENT INFORMATION

Date_____ Patient Name _____

☐ Male ☐ Female Birthdate_____ Home Phone _____

Address_____ City_____State_____ _Zip _____

E-Mail_____ _Cell Phone _____

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

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

Business address_____ City_____State_____ Zip_____

Spouse or parent/guardian's name_____Employer_____Work phone_____

If patient is a student, name school/college_____City_____ State_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone_____

In case of a medical emergency, if the child is of school age 15+, it is all right to treat in my absence.

X_____ Date _____

Patient or Guardian signature

Responsible Party

Name of person responsible for this account_____Relationship to patient_____

Address_____Home Phone_____

E-Mail_____Cell phone_____

Drivers License #_____Birthdate_____ Financial institution_____

Employer_____Work phone_____

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

Other Responsible Party

Name of person responsible for this account_____Relationship to patient_____

Address_____Home Phone_____

E-Mail_____Cell phone_____

Drivers License #_____Birthdate_____ Financial institution_____

Employer_____Work phone_____

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