	Patient Information
Patient Information	
Patient Name:	DOB: Sex:
Driver's License:	SSN:
Home Phone:	Cell:
Address:	
	Position:
Employer Address:	Phone No.
Emergency Contact Information	
Dependent?	If yes, Guardian's Name:
Guardian's Phone:	Cell:
Marital Status:	Spouse's Name:
Spouse's Employer:	Work Phone No.
Emergency Contact:	Relationship:
Home Phone:	Cell:
Emergency Contact:	Relationship:
Home Phone:	Cell:
Insurance	
Insured Party:	Relationship to Patient:
Insurance Company:	Phone No.
Address:	
Policy No.	Group No.
Dual Coverage?	2 <sup>nd</sup> Insurance Company:
Insured Party:	Relationship to Patient:
Phone No.	Address:
Policy No.	Group No.
Payment Method:	Card/Check No.

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.