Welcome

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THANK YOU FOR SELECTING US!

To help us meet all your health care needs, please fill out the following forms completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name: ______________________________ **M**___**F**___ **Date:** ________________

S.S. #: ____________ **Birthdate:** ________ **Home Phone:** ___________ **Cell:** ____________

Address: ________________________ **City:** ______________ **State:** ____ **Zip:** ________

Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Spouse or Parent's Name: _________________________ **Phone #:** _______________

Whom May We Thank for Referring You? ______________________________________

Person to Contact in Case of Emergency: ______________________ **Phone #:** ___________

To Confirm Appointments:

Phone #: ________________ **Home/Cell/Work (Please Circle) Text #:** _________________

Email: ____

Responsible Party

Name of Person Responsible for this Account: ____________________ **Relationship to Patient:** _________

Address: ____ **Home Phone:** ___________

City: ______________ **State:** _____ **Zip:** _______ **Drivers Lic. :** ________ **Birthdate:** ______

Employer: ________________________ **Work Phone:** ___________ **SS#:** _____________

Is this Person Currently a Patient in our Office? ☐ **Yes** ☐ **No**