



Patient Demographics

Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Gender: _____ SSN: _____ - _____ - _____

Are you enrolled in school? **Yes/No** Full-Time Student ___ Part-Time Student ___

Do you smoke? **Yes/No** How often per day? _____ Religion : _____ (optional)

How did you hear about us? _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (If different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Preferred Phone: **Home Cell DO NOT CALL**

E-mail: _____

Insurance:

Primary Insurance Provider _____

Subscriber ID: _____ Group/Plan No: _____ Co-payment Amount: _____

Do you have a Secondary Insurance? **Yes/No** Secondary Provider: _____

Financially Responsible Contact: (Primary Insured Party, If Different Than Patient)

Name: _____ DOB: _____ Relationship to Patient: _____

Address Line 1: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Emergency Contacts:

Name: _____ Relationship to Patient: _____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____ Work: (____) _____ - _____

Patient Authorization for Treatment: _____ **Date:** _____

Parent or Guardian: _____ **Date:** _____