



Thank you for choosing our clinic for your health care needs. We are very happy you are here. In order to serve you to the best of our ability, we will need you to complete the following patient information and answer all questions on the subsequent questionnaires. We use this information to know you better and to file insurance for you, if applicable. Please be patient in providing us all the necessary information. We want you to reach your health care goals, so please be complete with your answers. **Again, Thank You!**

<b>PATIENT INFORMATION</b>	<b>CONTACT INFORMATION</b>
<p>Date: _____</p> <p>Patient Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Sex: M F Age: _____ Birthdate: __/__/__</p> <p>____ Single ____ Married ____ Divorced</p> <p>____ Separated ____ Widowed</p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Spouses Name: _____</p> <p>Spouse's Birthdate: __/__/__</p> <p>Occupation: _____</p> <p>Spouse's Employer: _____</p> <p>Name &amp; Location of Your Primary Care Physician: _____</p>	<p>Home #:(____) _____ - _____</p> <p>Work #:(____) _____ - _____</p> <p>Cell #:(____) _____ - _____</p> <p>E-mail: _____</p> <p>Best Time/ Place to reach you: _____</p> <p><b>IN CASE OF EMERGENCY, PLEASE CONTACT:</b></p> <p>Name: _____</p> <p>Relation: _____</p> <p>Best #: _____</p> <div data-bbox="857 1230 1365 1276"><b>INSURANCE</b></div> <p>In our office payment is due at time of service. As a courtesy we will submit billing to your Insurance carrier. If there is coverage, they will reimburse you directly. (excludes Kaiser, Medicare, &amp; Medicaid)</p>
<b>HOW DID YOU HEAR ABOUT US?</b>	
<p>____ Personal Referral Name: _____</p> <p>____ Internet Web Address: _____</p> <p>____ Phone ____ Our location ____ Advertisement ____ Other</p>	