PATIENT INFORMATION SHEET

Date:______________________ **Referred By:**__________________________

Patient's Name:_____________________________**SSN:**___________________ **Birthdate:**__________ **Age:**

Address: ____ **C/S/Z:**___________________________________

Phone #:_____________________ **Sex: M F** **Marital Status: M S W D** **No. of Dependents:**

Employer:_______________________________________ **Phone:**________________ **Occupation:**______________

Student? F/T P/T **Name of School:**____

Spouse:________________________________ **SSN:**_____________________ **Occupation :**___________________

Employer:______________________________ **Phone:**____

Emergency Contact Person:_________________________________ **Relationship:**__________________________

Address:____**Phone:**____________________________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:_____________________________________ **Relationship:**_______________________

Residence Address:____ **C/S/Z:**______________________________

Hm. Phone #:____ **SSN:**____

Employer: ____ **# of Years Employed:**

Employer's Address:____ **C/S/Z:**

Union Local No.:__________________ **Wk. Phone #:**___________________ **Dental Insurance:**__________________

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name:________________________________ **SSN:**_________________________________

Patient's Relationship to Insured: Self:__________ **Spouse:**_________**Child:**________**Other:**___________

Employer:_____________________________________ **Phone #:**______________ **Union Local:**___________

Insurance Company:______________________________________ **Group # :**___________________________

Claims address:____

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name:____ **SSN:**____________________

Patient's Relationship to Insured: Self:__________ **Spouse:**__________ **Child:**_______**Other:**_________

Employer:_____________________________________ **Phone #:**______________ **Union Local:**___________

Insurance Company:______________________________________ **Group # :**___________________________

Claims address:____

(Rev. 4/05)