

PATIENT INFORMATION

Title First Name Middle Initials Last Name Dated

Address Town State ZIP+4

Male Female Single Married Other Employed Full-time Student Part-time Student Other

Date-of-Birth SSN Sex (Circle One) Marital Status (Circle One) Employment (Circle One)

Employer or School Name Town Job Title

Home Phone Office/Extension/Whose Mobile Phone Emergency Number & Contact Child's School

Pharmacy Name/Phone/Fax Co-Clinician Name/Phone Primary Care Physician Name/Phone

Email Address (If used Regularly) Referring Physician or Other Source

PERSON RESPONSIBLE FOR BILLS

If Patient is Responsible for Bills there is no need to Re-enter Information here, otherwise Complete this Section

Title First Name Middle Initials Last Name

Address Town State ZIP+4

DOB SSN Sex Relationship to Patient

Home Phone Business Phone Mobile Phone Employer

Spouse/Significant Other, or Parents/Guardians of a Child Patient

First Name Last Name DOB Occupation/Comment

Husband/Father

Wife/Mother

Children of an Adult, or Siblings of a Child Patient, and/or Others Living in Home

First Name Last Name DOB In Home Optional Comment

If you have Insurance complete Primary Insurance page else go to Signatures Page