NEW PATIENT INFORMATION
PLEASE PRINT

Patient Information

Patient's Name: _____ **Marital Status:** _____

Address: _____ **Apt#** _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Contact# _____ **Secondary Contact#** _____

Date of Birth: _____ **Social Security#** _____ **Employer:** _____

Email Address: _____

Emergency Contact Information

Name: _____ **Relationship to Patient:** _____

Primary Contact# _____ **Secondary Contact#** _____

Guarantor Information

Guarantor's Name: _____

Address: _____ **Apt#** _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Contact# _____ **Secondary Contact #** _____

Date of Birth: _____ **Social Security#** _____ **Employer:** _____

I understand that it is required that I bring to my appointment my Insurance Card and a Photo ID.

I have read the document titled INSURANCE WAIVER and understand that some charges may not be covered by my insurance plan and that I may be responsible for payment, in full, of these charges.

I understand that my insurance plan may not cover the AFTER HOURS charge that is an additional charge for appointments at and after 5:00pm M-F, on Saturdays, days designated as holidays, and as an emergency working during regular office hours. *I understand that I will be responsible for payment of these charges.*

_____

Signature

(Rev: bcf 09.07.09)