Welcome

Patient # _____

SS#/SIN _____

Date _____

Patient Information   (CONFIDENTIAL)

Name _____   Birthdate _____   Home Phone _____

Address _____   City _____   State/Prov. _____   Zip/P.C. _____

Email _____   Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____   City _____   State/Prov. _____   ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____   Work Phone _____

Business Address _____   City _____   State/Prov. _____   Zip/P.C. _____

Spouse or Parent/Guardian's Name _____   Employer _____   Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____   Phone _____

Responsible Party

Name of Person Responsible for this Account _____   Relationship to Patient _____

Address _____   Home Phone _____

Email _____   Cell Phone _____

Driver's License# _____   Birthdate _____   Financial Institution _____

Employer _____   Work Phone _____   SS#/SIN _____

Is this person currently a patient in our office?   ☐ Yes   ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash   ☐ Personal Check   Credit Card ☐ VISA   ☐ MasterCard   ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____   Relationship to Patient _____

Birthdate _____   SS#/SIN _____   Date Employed _____

Name of Employer _____   Union or Local # _____   Work Phone _____

Address of Employer _____   City _____   State/Prov. _____   Zip/P.C. _____

Insurance Company _____   Group # _____   Policy/ID # _____

Ins. Co. Address _____   City _____   State/Prov. _____   Zip/P.C. _____

How much is your deductible? _____   How much have you used? _____   Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?   ☐ Yes   ☐ No   IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____   Relationship to Patient _____

Birthdate _____   SS#/SIN _____   Date Employed _____

Name of Employer _____   Union or Local # _____   Work Phone _____

Address of Employer _____   City _____   State/Prov. _____   Zip/P.C. _____

Insurance Company _____   Group # _____   Policy/ID # _____

Ins. Co. Address _____   City _____   State/Prov. _____   Zip/P.C. _____

How much is your deductible? _____   How much have you used? _____   Max. annual benefit _____

Over Please