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### NEW PATIENT INFORMATION

Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Driver's License No. and State \_\_\_\_\_

Marital Status: Single  Married  Other  Date of Birth: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Custodial Parent(s) Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Parent's Date of Birth: \_\_\_\_\_ Relationship to Insured: Spouse  Child  Other

**Insurance Company Information**

**Primary Insurance**

**Primary Card Holder's Information:**

Primary Card Holder's Name: \_\_\_\_\_

Primary Card Holder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please note: (employer information is required from the insurance company)**

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**(PLEASE ADVISE US IF YOU ARE ON MEDICARE OR MEDICAID!)**

**(Please advise us if you have secondary insurance and present your card for us to copy)**

**Secondary Insurance**

Not Applicable

**Secondary Card Holder's Information:**

Secondary Card Holder's Name: \_\_\_\_\_

Secondary Card Holder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please note: (employer information is required from the insurance company)**

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_