



**Patient Information**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Marital Status: Single \_\_\_ Married \_\_\_ Widowed: \_\_\_ Other \_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_  
Email Address(Not used for solicitation purposes) : \_\_\_\_\_

**Employment Information: (if minor skip to next section)**

Retired: \_\_\_ Yes \_\_\_ No Unemployed: \_\_\_ Yes \_\_\_ No  
Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Work Address: \_\_\_\_\_

**Responsible Party Information:**

**Who is responsible for this account (if different from above):**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Where Employed: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
Responsible Party's Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
If patient is a minor, relationship to patient: \_\_\_\_\_

**Insurance Information:**

Primary **Medical** Insurance Company: \_\_\_\_\_  
Identification/Policy #: \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Subscriber (primary person on insurance) \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to subscriber: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_

Secondary **Medical** Insurance Company: \_\_\_\_\_  
Identification/Policy # : \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Subscriber (primary person on insurance) \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to subscriber: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_

**Vision Insurance**

Identification/Policy #: \_\_\_\_\_  
Name of Subscriber (primary person on insurance) \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to subscriber: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_  
Does your insurance require a referral from your primary care physician? Yes \_\_\_ No \_\_\_

\*\*\*\*\*Please give receptionist your card to copy\*\*\*\*\*

Who is your primary physician? \_\_\_\_\_ City/State \_\_\_\_\_  
Referring Physician's Name: \_\_\_\_\_ City/State \_\_\_\_\_  
How did you hear about us? \_\_\_ Word of Mouth \_\_\_ Phone Book \_\_\_ Internet \_\_\_ Insurance