Patient Information ❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ___/___/___

Name ____
Last *First* *M.I.*

Date of Birth: ___/___/___ Age: _____ Sex: ❑ Male ❑ Female Preferred Language: English /_________

Race: White, Native American, Asian, Black, Nat Hawaiian,Other **Ethnic Group:**Hispanic/Latino, Not Hispanic, Unknown

ADDRESS:

Mailing Address ____
City *State* *Zip*

Home Phone: ( )_____________________ Work Phone: ( )_____________________

Cell Phone: ( )_____________________ e-mail: _____________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY ***(if different from patient)***

Name: ____Date of Birth: ___/___/___
Last *First* *M.I.*

Address:____
City *State* *Zip*

Home Phone: ( )_____________________ Work Phone: ( )_____________________

INSURANCE COVERAGE - __PRIMARY:__

Insurance Co. Name:________________________________

Address of Claim Center:____

____
City *State* *Zip Code*

Name of Policy Holder (Insured):________________________________

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____________________ Group Name or #:_____________________

Policy Type: ❑ HMO ❑ PPO

If patient is child, check relationship to insured: ❑ Mother ❑ Father ❑ Other_______________

INSURANCE COVERAGE - __SECONDARY:__

Insurance Co. Name:________________________________

Address of Claim Center:____

____
City *State* *Zip Code*

Name of Policy Holder (Insured):________________________________

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____________________ Group Name or #:_____________________

Policy Type: ❑ HMO ❑ PPO

If patient is child, check relationship to insured: ❑ Mother ❑ Father ❑ Other_______________

Please present your insurance card(s) and a photo ID
to the receptionist along with this completed form. Thank you.