Office Use Only: LMP **Referred by:** **Seeing:**

Patient Name: _____
last name first name middle initial

Responsible Party (if a minor):_____

Mail Address: _____

City _____ State _____ Zip _____

Birth Date _____ / _____ /_____ Social Security Number _____

Home Phone _____Cell Phone _____ Work Phone _____

DO WE HAVE YOUR PERMISSION TO CALL:

YOUR HOME: YES/NO **LEAVE A MESSAGE:** YES/NO **YOUR CELL:** YES/NO **LEAVE A MESSAGE** YES/NO

YOUR WORK: YES/NO **LEAVE A MESSAGE** YES/NO Employer Name_____

E-MAIL PREFERRENCES: Send appt reminders YES/NO **Send test results** YES/NO

E-MAIL ADDRESS _____

Primary Insurance_____

Group Number _____

Contract Number _____

Subscribers Name _____

Subscribers Soc. Sec. # _____

Subscribers birth date _____

Sex _____ Relationship to patient _____

Address of subscriber (if different from Patient.):

_____

_____

_____

Secondary Insurance_____

Group Number _____

Contract Number _____

Subscribers Name _____

Subscribers Soc. Sec. # _____

Subscribers birth date _____

Sex _____ Relationship to pt. _____

Address of subscriber (if different from Patient.):

_____

_____

_____

In case of emergency, contact _____ Phone _____

Does patient have Advance Directive ? Yes / No (circle answer) Desire Information ? Yes / No (circle answer)

Spouse Name _____ Spouse birth date _____

I certify that the above information is complete and accurate to the best of my knowledge. I also understand I am responsible for the timely payment of all insurance copays and deductibles. If uninsured, I agree to full payment at the time of service. _____ _____
signature date

Please complete reverse side