



# Welcome

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Information

Street Address \_\_\_\_\_  
 City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home phone \_\_\_\_\_  
 Work phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 If patient is a full-time student, name of school \_\_\_\_\_  
 Employer \_\_\_\_\_ Address \_\_\_\_\_  
 \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_ Driver's License State & Number \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

### Primary Insurance

Primary Insurance

Policy Holder \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address (if different than patient) \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_ Policy Holder employed by \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 SS# \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_  
 Subscriber # \_\_\_\_\_  
 Insurance Company Address \_\_\_\_\_ City/State \_\_\_\_\_  
 Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Additional (Secondary) Insurance

Secondary Insurance

Is patient covered by additional insurance?  Yes  No  
 Policy Holder \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address (if different than patient) \_\_\_\_\_  
 City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Policy Holder employed by \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 SS# \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_  
 City, State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Coverage Change - Primary change \_\_\_\_\_ Secondary change \_\_\_\_\_ (please check)

Change in Insurance

Date \_\_\_\_\_ Policy Holder \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address (if different than patient) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Policy Holder employed by \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 SS# \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_  
 Subscriber # \_\_\_\_\_  
 Insurance Company Address \_\_\_\_\_ City/State \_\_\_\_\_  
 Zip Code \_\_\_\_\_ Phone \_\_\_\_\_



Signature - Person Responsible for Account

Date