Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need any assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ______________________ Date ______________________

SS# / SIN ______________________ Birthdate ______________________ Home Phone ______________________

Address ______________________ City ______________________ State/ Prov. ______________ Zip/P.C. ______________

Email ______________________ Cell Phone ______________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College ______________________ City ______________________ State/ Prov. ______________ Zip/P.C. ______________

☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer ______________________ Work Phone ______________________

Business Address ______________________ City ______________________ State/Prov. ______________ Zip/P.C. ______________

Spouse or Parent/Guardian's Name ______________________ Employer ______________________ Work Phone ______________________

Whom May We Thank for Referring You? ______________________

Person to Contact in Case of Emergency ______________________ Phone ______________________

Responsible Party

Name of Person Responsible for This Account ______________________ Relationship to Patient ______________________

Address ______________________ Home Phone ______________________

Email ______________________ Cell Phone ______________________

Birthdate ______________________ SS# / SIN ______________________

Employer ______________________ Work Phone ______________________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ Mastercard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______________________ Relationship to Patient ______________________

Birthdate ______________________ SS# / SIN ______________________ DateEmployed ______________________

Name of Employer ______________________ Union or Local # ______________________ Work Phone ______________________

Employer Address ______________________ City ______________________ State/Prov. ______________ Zip/P.C. ______________

Insurance Company ______________________ Group # ______________________ Policy/ ID# ______________________

Ins. Co. Address ______________________ City ______________________ State/Prov. ______________ Zip/P.C. ______________

How Much is Your Deductible? ______________ How Much Have You Used? ______________ Max. Annual Benefit ______________

Do You Have Any Additional Insurance? ☐ Yes ☐ No If yes, please complete the following.

Name of Insured ______________________ Relationship to Patient ______________________

Birthdate ______________________ SS# / SIN ______________________ DateEmployed ______________________

Name of Employer ______________________ Union or Local # ______________________ Work Phone ______________________

Employer Address ______________________ City ______________________ State/Prov. ______________ Zip/P.C. ______________

Insurance Company ______________________ Group # ______________________ Policy/ ID# ______________________

Ins. Co. Address ______________________ City ______________________ State/Prov. ______________ Zip/P.C. ______________

How Much is Your Deductible? ______________ How Much Have You Used? ______________ Max. Annual Benefit ______________