Please Print

Today's Date		☑ Please check the box next to all phone numbers, addresses and email addresses which are confidential. The check means you give us permission to send healthcare information such as test results to those addresses or leave it on your voicemail.

PATIENT INFORMATION

Full Legal Name (Last) (First) (Middle)				Name Normally Used (Nickname)
Date of Birth	Age	Gender		
Home Phone ☐	Work Phone (including extension) ☐			Cell Phone ☐
Address (Number) (Street) (Apt. No.) ☐				
City	State			Zip
How Did You Hear About Us?				

INSURANCE POLICY HOLDER INFORMATION

Full Legal Name (Last) (First) (Middle)				**Do you have legal custody? Y N**
Patient's relationship to guarantor				Date of Birth
Address (If Different From Above)			**Email address** ☐	
City	State			Zip
Home Phone ☐	Work Phone (including extension) ☐			Cell Phone ☐

CONTACT INFORMATION

Name of guardian				Relationship to patient
Home Phone ☐	Work Phone (including extension) ☐			Cell Phone ☐
Address (If Different From Above) ☐				
City	State	Zip	**Email address** ☐	

ALTERNATE CONTACT INFORMATION

Name				Relationship to patient
Home Phone ☐	Work Phone (including extension) ☐			Cell Phone ☐
Address (Number) (Street) (Apt. No.) ☐				
City	State	Zip	**Email address** ☐	

EMERGENCY INFORMATION

Person to Notify in Case of Emergency				Relationship
Home Phone ☐	Work Phone (including extension)			Cell Phone ☐

For appointment reminders do you prefer ☐ Text Message ☐ Email ☐ Voicemail

☑ Don't forget to check all confidential numbers and addresses above.

Signature _____ SS# (required)_____

Print Name _____ Relationship _____