New Patient Information Record
(Please Print or Write Legibly. Please complete as thoroughly as possible.)

Referred By:		Referring Phy Phone:		Your Driver's License#
Name:	Marital Status: S M W D Sep.	Date of Birth:	Age:	Social Security #:
Street Address:	City:	State:		Zip Code:
Home Phone:	Work Phone:	Mobile Phone:		Email Address:
Employed By: (Indicate if Retired)		Occupation: (Indicate If Student and Give Name of School)		
Employer's Street Address:		City :	State:	Zip Code:
Person Responsible for Payment:		City, State & Zip Code:		Home Phone:
Spouse's Name:		Spouse's Social Security No.:		
Spouse Employed By (Indicate if Retired)	Occupation (Indicate if Student)	How Long Employed:		Bus. Phone:

Medical History

Nature of Problem:	Date Problem Began:
List Previous Treatment (If Any) For This Problem And/Or X-Rays Taken:	
List Medications Allergic To:	

Emergency Contact Information

Name:	Relationship:
Address:	Telephone Number:

If this is a Worker's Compensation, or Auto Accident, Please Complete the Following:

Date of Accident:	Name, Address, and Phone # of Attorney If Attorney is Handling This Case:
If Worker's Comp., Person to Contact to Verify:	Phone:

INSURANCE: Primary	**Secondary:**
COMPANY_____	**COMPANY**_____
ADDRESS_____	**ADDRESS**_____
PHONE_____	**PHONE**_____
EMPLOYER_____	**EMPLOYER**_____
INSURED'S NAME_____	**INSURED'S NAME**_____
GROUP#_____**POLICY#**_____	**GROUP#**_____**POLICY#**_____
ID# (S.S.#)_____	**ID# (S.S.#)**_____
INSURED'S DATE OF BIRTH_____	**INSURED'S DATE OF BIRTH**_____

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, AT THE TIME OF SERVICE, unless other arrangements are made in advance with the office. I understand and agree that health insurance policies are in arrangement between an insurance carrier and myself. I will take the responsibility for any and all costs incurred by my failure to remit for service rendered. I authorize payment of medical benefits to the physician herein for medical services rendered. A photocopy of this signature is as valid as the original. I also authorize the physician to release any information required in processing of insurance.

Signed _____ Date _____