Patient Record

PLEASE PRINT

DATE _____

PATIENT'S NAME _____ NAME USED _____

MALE ___ FEMALE ___ DATE OF BIRTH _____ SOCIAL SECURITY # _____

STREET ADDRESS _____

APARTMENT # _____ SPACE # _____ CELL PHONE (____) _____ PAGER (____) _____

CITY _____ STATE _____ ZIP _____ PHONE (____) _____

MAILING ADDRESS _____

E-MAIL ADDRESS _____

KNOWN DRUG ALLERGIES _____

REFERRED BY _____ ADDRESS _____

FAMILY DOCTOR _____ ADDRESS _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____

IF PATIENT IS MARRIED

SPOUSE _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ PHONE (____) _____

IF PATIENT IS MINOR OR COVERED BY PARENT'S INSURANCE

FATHER _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ PHONE (____) _____

MOTHER _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ PHONE (____) _____

NAME OF NEAREST RELATIVE
OR FRIEND NOT LIVING WITH YOU _____

ADDRESS _____ PHONE (____) _____

PRIMARY INSURANCE

COMPANY _____

ADDRESS _____ PHONE (____) _____

GROUP # _____ GROUP NAME _____ ID # _____

SECONDARY INSURANCE

COMPANY _____

ADDRESS _____ PHONE (____) _____

GROUP # _____ GROUP NAME _____ ID # _____

OTHER INSURANCE

COMPANY _____

ADDRESS _____ PHONE (____) _____

GROUP # _____ GROUP NAME _____ ID # _____

I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY BY PHYSICIAN, AND AUTHORIZE PAYMENT TO PHYSICIAN BY MY INSURANCE COMPANY.

_____

PATIENT OR RESPONSIBLE PARTY