



Today's Date  
\_\_\_ / \_\_\_ / 20 \_\_\_

Patient	Responsible Party - if different than patient Patient Relationship <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Legal Last Name	
Legal First Name, Middle	
Social Security #	
Date of Birth	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female

Mailing Address  
Apt/Bldg/Suite#  
City, State, Zip Code


Home Phone  
Work Phone  
Cell Phone  
E-mail address

(    )	(    )
(    )	(    )
(    )	(    )

Employer  
Mailing Address  
City, State, Zip Code


Name of Insurance  
Policy#  
Group # (if applicable)

Primary Insurance - if applicable	Secondary Insurance - if applicable

**Primary Policyholder**

Same as patient  Same as Responsible Party       Same as patient  Same as Responsible Party

*(if different than patient or responsible party)*  
Name  
Date of Birth  
Social Security #  
Sex  
Employer

<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female

Emergency Contact \_\_\_\_\_ Phone (    ) \_\_\_\_\_ Alt. Phone (    ) \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Are we your Primary Care Physician (PCP)?  Yes  No **If we are not your primary care physician,** Please provide...

Doctor Name and/or Practice Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone # (if known) (    ) \_\_\_\_\_

Would you like notes from today's visit forwarded to your Primary Care Physician (PCP)?  yes  no