

NEW PATIENT INFORMATION



Patient Information

Last Name _____ First Name _____ M.I. _____
Date of Birth: ___/___/___ SSN: ___-___-___ Marital Status: _____ Sex: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
Employer / School Name: _____ Phone #: (____) _____
Email address: _____ Would you like to receive newsletters/specials on:
 Sleep & Snoring Facial Cosmetics Hearing Loss/Care

Emergency Contact

1st Name: _____ Phone number: _____ Relationship: _____
2nd Name: _____ Phone number: _____ Relationship: _____

Guarantor / Responsible Party Same as above

Relationship to Patient: _____
Last Name _____ First Name _____ M.I. _____
Date of Birth: ___/___/___ SSN: ___-___-___ Driver's License / State: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone (____) _____
Employer / School Name: _____ Phone #: (____) _____

Insurance Information

Subscriber / Employee's Name: _____ Employer: _____
Date of Birth: ___/___/___ SSN: ___-___-___ Patient's Relationship to Insured: _____
Insurance Co Name: _____ Phone (____) _____
ID #: _____ Group #: _____

Do you have a Secondary Insurance? No, Initial _____

Yes, Subscriber / Employee's Name: _____ Employer: _____
Date of Birth: ___/___/___ SSN: ___-___-___ Patient's Relationship to Insured: _____
Insurance Co Name: _____ Phone (____) _____
ID #: _____ Group #: _____

Referral Information

How did you hear about us?
Dr. Referral Family/Friend Internet Insurance Yellow Pages Radio Magazine _____ Other _____
Referring Person: Last Name _____ First Name: _____ Phone number: _____