Patient Information:

Print Name: ____ Date:____________

First MI Last

Address: ____

Street City State Zip Code

Age:_______ Birth Date: _____________ Gender: Male / Female Marital Status:__________

Email Address: ____

Home Phone: ____________________ Cell:_____________________ Work: _______________

I prefer to receive calls at (circle): Home / Cell / Work

Can we leave a message regarding your treatment? Yes / No

Whom may we thank for referring you? ____

Referring Physician: __________________________ Phone Number:_____________________

Employer: ________________________________ Occupation: ___________________________

Emergency Contact: __________________________ Phone Number: _____________________

Payment Information:

PRIMARY Insurance Company: ____

Policy Holder's Name: ______________________________________ Date of Birth: __________

Relationship to Patient: ____

SECONDARY Insurance Company: ____

Policy Holder's Name: ______________________________________ Date of Birth: __________

Relationship to Patient: ____

Consent/Acknowledgement:

The following is information required by the American Recovery and Reinvestment Act of 2009.

My primary language is:____

Race: *(Please circle)* > > > > > > > > AND > > > > > > > > > > **Ethnicity:** *(Please circle)*

White

American Indian/ Alaska Native

Asian

Black/ African American

Native Hawaiian/ Other Pacific Islander

Other:___________________________

I Decline To Answer

Hispanic or Latino

Not Hispanic or Latino

I Decline to Answer

I acknowledge/consent to the information presented to me regarding Privacy Practices(HIPPA), Professional Treatment, Assignment of Benefits, Release of Records and Financial Obligation. If patient is a minor, by signing I give consent for examination, tests and/or procedures for the above named minor patient.

Signature:____ Date:____________