

**New/Reactivated Patient Information:**

Appointment Date: \_\_\_\_\_ Account #: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Marital Status: \_\_\_\_\_  
Referring Physician's Name: \_\_\_\_\_  
Referring Physician's Phone Number: \_\_\_\_\_  
Referring Physician's Address: \_\_\_\_\_

**Insurance Information**

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
<p>Primary Insurance: _____ Insured's Name: _____ Policy #: _____ Group #: _____</p>	<p>Secondary Insurance: _____ Insured's Name: _____ Policy #: _____ Group #: _____</p>
<p>Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse to Insured: <input type="checkbox"/> Child <input type="checkbox"/> Other</p>	<p>Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse to Insured: <input type="checkbox"/> Child <input type="checkbox"/> Other</p>
<p>Insured's Employer: _____ Insured's DOB: _____</p>	<p>Insured's Employer: _____ Insured's DOB: _____</p>

Patient Employer: \_\_\_\_\_ Full Time Student:  Yes  No  
Occupation: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Relationship of Emergency Contact: \_\_\_\_\_  
Emergency Contact's Phone Number: \_\_\_\_\_  
Name of Parent or Guardian if Patient is a Minor: \_\_\_\_\_  
How were you Referred? \_\_\_\_\_  
 Physician  Family  Friend  Phone Book  Insurance Co.  Magazine  
 Internet/ "FindADoctor" Website  Care Credit  Other  
Race: \_\_\_\_\_  
Patient's Email Address: \_\_\_\_\_