Patient Information Questionnaire

Last Name | First | MI | Date of Birth | Social Security #

Preferred Name | Home Phone # | Cell Phone # | Work Phone #

Patient's Address | Street | City | Zip | E-MAIL

Who may we thank for referring you to our office? | Pharmacy location/phone #

EMERGENCY CONTACT INFORMATION

Name of Contact | Relationship

Home Phone # | Cell Phone # | Work Phone #

INSURANCE INFORMATION

Insurance Company Name | Insurance Address | Insurance Phone #

Subscriber's Name | Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Dependent | Subscribers DOB | Subscriber's ID#

Group/Program # | Employer

CONFIRMATIONS

Do you prefer a confirmation call?

◯ Yes, it is a helpful reminder

◯ No, I would like to be contacted by email or text

I consent to making of videotapes, photographs, and xrays before, during and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read this form and agree with its contents.

Patient's Signature | Date