Patient Information Sheet

Patient:

Last Name:________________________________First Name:________________________Middle:__________
Gender: M F Date of Birth: _____/_____/_______ Age: __________
Social Security Number: ____
Home Address:____ Apt/Suit #:_________________
City:___________________________________ State:____________________ZipCode:___________________
Email:____
Home Phone:________________________________Cell Phone:_______________________________________
Work Phone:________________________________
Best way to contact you (please check): Cell Phone □ Home Phone □ Text Message □ Email □
Occupation:_______________________________________ Employer: _________________________________
Employer Address:____
City:_______________________________________State:__________________ Zip Code:___________________

Emergency Contact:

Last Name:_______________________________First Name:__________________________Middle:___________
Relationship to Patient: ____
Contact Phone Number:____

Insurance: ***Not Applicable***

WE DO NOT CURRENTLY ACCEPT INSURANCE. SUPERBILLS AVAILABLE UPON REQUEST.

Insurance Company:____
Insured Last Name:___________________________First Name:____________________________Middle:______
Insured's Policy/ID #:_____________________________________Phone:_________________________________

Insurance Company:____
Insured Last Name:___________________________First Name:____________________________Middle:______
Insured's Policy/ID #:_____________________________________Phone:_________________________________

Responsible Party: Complete this section if you are NOT the patient but are responsible for the bill.

Last Name:_____________________________First Name:___________________________Middle:____________
Relation to Patient:_____________________________________ Work Phone:______________________________
Home Phone:_________________________________Cell Phone:____
Home Address:____ Apt/Suit #:_________________
City:___________________________________ State:____________________ZipCode:___________________
Occupation:_______________________________________
Employer and Address:____
City:_______________________________________State:__________________ Zip Code:___________________

Additional Questions:

Do you smoke, drink coffee, or alcohol? (if yes, indicate how much)
Cigarettes _____________________ Coffee ______________________ Alcohol _______________________
Are you taking nutritional supplements? If yes, which ones? ____

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Comments/Suggestions: ____

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