

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**

1<sup>st</sup> Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_  
2<sup>nd</sup> 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: \_\_\_\_\_