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

1st Name: ___________________________ Phone number: ____________________ Relationship: ____________

2nd 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: ________