PATIENT'S FIRST NAME: _____ **MIDDLE**: _____

LAST: _____ **PATIENT'S GENDER**: M ☐ F ☐

PATIENT'S SOCIAL SECURITY NUMBER: _____ **PATIENT'S BIRTH DATE**: _____/_____/_____

STREET: _____ **CITY**: _____ **STATE**: _____ **ZIP CODE:** _____

PLEASE CHECK BOX FOR PREFERRED PHONE NUMBER TO CALL. ☐ Check if you would like text messages.

☐ **HOME PHONE**: _____ **EMAIL ADDRESS**: _____

☐ **CELL PHONE**: _____ **SERVICE PROVIDER:** _____

REFERRED BY: _____ **EMERGENCY CONTACT**:_____ **PHONE:**(_____)_____-_____

PRIMARY POLICY HOLDER: ☐ Self OR ☐ SPOUSE ☐ CHILD ☐ OTHER

FIRST: _____ **MIDDLE**: _____ **LAST**: _____

POLICY HOLDER'S BIRTH DATE: _____/_____/_____ **INSURED'S SSN**: _____ **GENDER**: M ☐ F ☐

STREET: _____ **CITY**: _____ **STATE**: _____ **ZIP CODE:** _____

PHONE: _____

If Applicable: SECONDARY POLICY HOLDER: ☐ Self OR ☐ SPOUSE ☐ CHILD ☐ OTHER

FIRST: _____ **MIDDLE**: _____ **LAST**: _____

SECONDARY'S BIRTH DATE: _____/_____/_____ **INSURED'S SSN**: _____ **GENDER**: M ☐ F ☐

STREET: _____ **CITY**: _____ **STATE**: _____ **ZIP CODE:** _____

PHONE: _____

Patient Signature: _____ DATE: _____/_____/_____

Parent/Guardian Signature if Patient is a Minor:_____ **DATE**: _____/_____/_____