Confidential Client Information

Personal Information

NAME: GENDER (M/F): DATE OF BIRTH:

HOME ADDRESS: CITY: STATE: ZIP:

HOME PHONE: CELL PHONE:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Live as Married

EMPLOYER/SCHOOL: WORK PHONE:

ADDRESS: CITY: STATE: ZIP:

OK to call: ❑ Home ❑ Work ❑ Restrictions on messages:

Other Members of the Household

NAME : RELATIONSHIP: DATE OF BIRTH:

NAME : RELATIONSHIP: DATE OF BIRTH:

NAME : RELATIONSHIP: DATE OF BIRTH:

NAME : RELATIONSHIP: DATE OF BIRTH:

Medical Information

PHYSICIAN: DATE OF LAST VISIT: PHONE:

ADDRESS: CITY: STATE: ZIP:

REFERRED TO THIS OFFICE BY:

CURRENT MEDICATIONS & DOSAGES:

ALLERGIES:

CURRENT MEDICAL PROBLEMS OR TREATMENT:

EMERGENCY CONTACT: PHONE:

Insurance Information

RESPONSIBLE PARTY & INSURANCE INFORMATION

RESPONSIBLE PARTY/INSURED: SSN: DOB:

HOME ADDRESS: CITY: STATE: ZIP :

EMPLOYER ADDRESS: CITY: STATE: ZIP :

HEALTH INSURANCE CARRIER: PHONE:

INSURANCE ADDRESS: CITY: STATE: ZIP:

IDENTIFICATION#: GROUP #: EFFECTIVE DATE:

DEDUCTIBLE AMOUNT: HAS DEDUCTIBLE BEEN MET (Y/N): BENEFIT %: CO-PAY/CO-INS $:

PREAUTHORIZATION REQUIRED (Y/N): CONTACT NUMBER FOR PREAUTHORIZATION:

DESCRIBE LIMITS/RESTRICTIONS ON COVERAGE:

SIGNATURE OF CLIENT OR PARENT/LEGAL GUARDIAN: DATE:

PLEASE REQUEST A SECOND FORM IF YOU HAVE SECONDARY INSURANCE:

Office Use Only

DX CODING PRIMARY: SECONDARY:

NOTES: