☐ New Patient	☐ Updated Informatio
- New Fatient	





Patient Name:						Birth Date://					
	LAST		FIRST		MI						
Social Security	No:	-	<u>-</u>		Gender:		Male		Female		
Address:	F ADDDESS			CITY			CTATE		ZIP		
Address:			CITY			STATE					
Home #:	ome #: Cell #:					Work #:					
Marital Status:	☐ Married	l □ Single	e □ Divorced	│ □ Widov	ved Pro	eferred	d Langua	ge:			
Race:			☐ American Pacific Island	•			an □ Hisp	anic			
Ethnicity:	□ Hispani	c or Latin [Decent □ No	ot Hispanic	or Latin D	ecent [□ Do Not \	Wish to I	Report		
Emergency C	Contact I	<u>nformat</u>	<u>ion</u>								
Name:						Ph	none:		<u>-</u>		
Release of M	edical Ir	<u>ıformati</u>	<u>on</u>								
(Medical Informa	tion may be	e released t	to the followi	ing individu	ıals)						
Name:	Relationship			nship: _		Phone:					
Name:		Relationship:				Phone:					
Payment Inf	<u>ormatior</u>	<u>1</u>									
Form of Payment	: □ Healt	h Insuranc	e 🗆 Auto I	nsurance	□ Workers	s Comp	□ Self P	ay 🗆 (Other		
Primary Insura	ance:										
Primary Company:					Insured's Name:						
Policy #:		Gro	oup #:		Insur	ed's Da	ate of Birt	:h:			
Secondary Ins	<u>urance</u>										
Secondary Company:				Insured's Name:							
Policy #:		Group #:			Insu	Insured's Date of Birth :					
Self Pay Agree	<u>ment</u>										
I agree to pay f that payment a								e, PLLC	. I understar	nd	
Patient Signati	ure:						Date: _				