

New Patient

Name _____ Sex **F M** Date of birth ____ / ____ / ____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ - _____ - _____ Business Telephone _____ - _____ - _____

Cell phone _____ - _____ - _____ Social Security No. ____ / ____ / ____

Marital status: **S D M W** E-mail address: _____ if none check here ()

May we send you our bi-weekly newsletter? YES () NO ()

Occupation _____ Who referred you to our office? _____
(Please circle one: indicate if child, student, housewife, unemployed, or retired)

Employer's Name _____ Employer's address _____

Spouse Name _____ Social Security No. ____ / ____ / ____

Spouse employer _____ Address _____

Spouse Telephone No. _____ - _____ - _____

Emergency contact _____ Address _____

Emergency Contact Phone _____ - _____ - _____

Primary Insurance Company To Bill _____ Address _____

Telephone No. _____ - _____ - _____ Policy No. _____

Secondary Insurance Company To Bill _____ Address _____

Telephone No. _____ - _____ - _____ Policy No. _____

Are you the primary insured Yes () No () if no, name: _____

IF THE FOLLOWING COMPLAINT IS THE RESULT OF A WORKER'S COMPENSATION INJURY OR AN AUTOMOBILE ACCIDENT, PLEASE INFORM THE FRONT DESK IMMEDIATELY.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in the patient's chart and maintained for six years.

Patient's Name (please print) _____ Date ____ / ____ / ____

Signature _____ Parent, Guardian or Patient's legal representative