



**ADULT**

**Today's Date:** \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Sex** \_\_\_\_\_  
**SSN#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_  
**Home#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Cell#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
**Employee Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_  
**Primary Physician's Name/Phone#** \_\_\_\_\_  
**Referring MD** \_\_\_\_\_  
**Email Address** \_\_\_\_\_  
**Emergency Contact** \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**SSN#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Cell#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
**Employee Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Insurance Information**

**Primary Insurance** \_\_\_\_\_ **Policy #** \_\_\_\_\_  
**Name of Policy Holder** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Group #** \_\_\_\_\_  
**Secondary Insurance** \_\_\_\_\_ **Policy #** \_\_\_\_\_  
**Name of Policy Holder** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Group #** \_\_\_\_\_

I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize said assignee to release any information necessary to secure payment on my behalf. I authorize release of my medical records.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_