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PATIENT INFORMATION FORM

Name of patient: _____

Sex of patient: _____ Male _____ Female

Date of patient's birth: _____ / _____ / _____ Age of patient: _____

Grade level of patient (if applicable): _____

Name of patient's parent/guardian (if applicable): _____

Address of patient: _____

_____

Address of patient's parent/guardian (if applicable): _____ Place "X" here if same as above

_____

_____

Billing address (including name of responsible party at billing address):

_____ Place "X" here if same as above

_____

_____

Patient's telephone number:

(_____)_____

Patient's/parent's/guardian's e-mail address: _____

Does patient/parent/guardian check his/her e-mail on a regular basis (i.e., once a day):

_____ Yes _____ No (NOTE: E-mail addresses are helpful in the event appointments need to be rescheduled or other information is required from the patient/parent/guardian or is to be communicated to these individuals. E-mail addresses will be kept confidential.)

Parent/guardian's **work telephone number** (if applicable):

Name of parent/guardian: _____ Work number: (_____)_____

Patient's marital status: _____ Married _____ Separated _____ Divorced _____ Single

School patient attends (if applicable): _____

Patient's homeroom teacher (if applicable): _____

Patient's physician/pediatrician: _____

Is patient presently taking medication? _____ Yes _____ No

If yes, type and dosage level of medication: _____

INSURANCE INFORMATION

Primary insurance company name: _____

Name of insured: _____ Insured's date of birth: _____

Insured's address (if different from address above): _____

Insured's place of employment: _____

Patient (<u>if someone other than the insured</u>) is insured's: _____ Spouse/partner _____ Child

_____Other (specify) _____

Insured's member or subscriber identification number on front of insurance card:

_____

Insured's group or account number on insurance card (if applicable): _____