

**WELCOME TO OUR OFFICE**

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

Patient Name: \_\_\_\_\_

Last

First

Middle

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (     ) \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Telephone: (     ) \_\_\_\_\_ Length of Employment: \_\_\_\_\_

**Complete this section only if someone other than the patient is responsible**

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (     ) \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Telephone: (     ) \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Telephone: (     ) \_\_\_\_\_ Length of Employment: \_\_\_\_\_

In Case of Emergency, Contact: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

How did you learn about our clinic?

Dr. Referral                       Previous Patient                       Friend

Yellow Pages                       Sign                       Other

Please Be Specific about name of referral: \_\_\_\_\_

Referred By: Dr. \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_