New Patient Information

Patient's Name ______________________ Date of Birth(DOB) ______________ Sex M / F
Last First MI
Social Security Number ______________________ Name Patient Prefers ______________

Patient's Home Address

Street ____
City ______________ State ________ Zip ________ Phone # ______________
School/Grade ____

Family

Names and ages of siblings in family
____
Do parents live together? ___ yes ___ no If not, with whom does the child reside? ______________

Parent or Guardian Information

Name ______________________ _____ Mother _____Father _____Guardian (check one)
DOB ______________ SS# ______________
Employer ______________________ Occupation ______________________
Home # ______________ Work # ______________ Cell # ______________
Marital Status ______________ E-Mail address ______________________

Name ______________________ _____ Mother _____Father _____Guardian (check one)
DOB ______________ SS# ______________
Employer ______________________ Occupation ______________________
Home # ______________ Work # ______________ Cell # ______________
Marital Status ______________ E-Mail address ______________________

Person Responsible for Account Payments ______________________ Driver's license # ______________

Method of Payment (Check One)

___Check or Cash At Time of Treatment ___ Debit Card ___ Visa ___ Master Card ___ Discover ___ Amex
___Insurance – plus co-payment at time of treatment SCMedicaid # ______________________

Insurance Information

Policy Holder's Name ______________________ Relationship ______________________
Employer ______________________ DOB ________ SS# ______________
Insurance Company Name/Address
____
Group # ______________ Policy # ______________ Insurance Phone # ______________

Whom may we thank for referring you to our office? ______________________

______________________ ______________
Signature of Legal Consent Date