

# Patient Information Sheet

Please fill out completely and please print neatly. Thank you.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

DOB: \_\_\_\_\_  Male  Female  Unspecified

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_  Single  Married  Other

Home Phone: ( ) \_\_\_\_\_ Mobile Phone: ( ) \_\_\_\_\_ **Preferred Method of Contact:**

Email  Text

Email: \_\_\_\_\_ Employed:  Y  N

Primary Health Practitioner: \_\_\_\_\_

Is this a Worker's Compensation Claim?  Yes  No

**Primary Insurance Provider:** \_\_\_\_\_

Self  Other \_\_\_\_\_

**Secondary Insurance Provider:** \_\_\_\_\_

Self  Other \_\_\_\_\_

**Tertiary Insurance Provider:** \_\_\_\_\_

Self  Other \_\_\_\_\_

## POA / Responsible Party if Patient is under 18

Full Name: \_\_\_\_\_ Email: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge. Also, by signing below I am giving permission to leave messages about appointments and/or medical reports at the personal address, personal phone number, email address and/or spouse or responsible party contact information. (Mark out any that should not be included.)

Patient's Signature: \_\_\_\_\_ Date: / /

Parent or Legal Guardian or POA: \_\_\_\_\_ Date: / /