Adult Information Sheet

Date: _____

Name: _____ D.O.B.:_____/_____/_____ Age:_____

Address _____

Street or P.O. Box City State Zip

SS#:_____-_____-_____ Spouse's Name: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ e-mail Address:_____

Address where statement should be sent if different than above:

_____

Employer: _____ May we contact you at work? ☐ Yes ☐ No

Present Position:_____ How long held? _____

Spouse's Employer:_____

Spouse's Present Position: _____ How long held? _____

How did you hear about us? _____

Whom may we thank for referring you to us?

Name: _____

Address: _____

Insurance Information

If you have insurance that will assist you with a portion of your account, please complete the following:

Employee Name: _____ D.O.B.:____/____/____ SS#:_____-_____-_____

Employer Name:_____ Insurance Company: _____

Insurance Company Mailing Address:_____

Group Number:_____ Is this insurance: ☐ Dental or ☐ Medical

Relationship of the patient to the insured: ☐ Self, ☐ Spouse, ☐ Child, ☐ Other

Additional Coverage

Employee Name: _____ D.O.B.:____/____/____ SS#:_____-_____-_____

Employer Name:_____ Insurance Company: _____

Insurance Company Mailing Address:_____

Group Number:_____ Is this insurance: ☐ Dental or ☐ Medical

Relationship of the patient to the insured: ☐ Self, ☐ Spouse, ☐ Child, ☐ Other