

## LET'S GET ACQUAINTED

First Name	Initial	Last Name		
Home Address		City	State	Zip
Work Name and Address		City	State	Zip
(____) _____	(____) _____	(____) _____		
Home Phone	Work Phone	Cell Phone		
/ /	Age	Patient's Social Security		
Birth Date				

## INSURANCE INFORMATION

Do you have health insurance?	Y	N
If not, how do you plan to pay for today's visit?	CASH	CHECK
		VISA/MC
If yes, does your insurance require a referral?	Y	N
If so, did you obtain a referral?	Y	N
How much is your co-payment for each visit?	\$	
How do you plan to pay for today's co-payment?	CASH	CHECK
		VISA/MC
Do you have more than one insurance plan covering your family?	Y	N

<b>Primary</b> Insurance Company	Identification Number	
Name of Policy Holder	Social Security Number	/ /
		Birth Date
<b>Secondary</b> Insurance Company	Identification Number	
Name of Policy Holder	Social Security Number	/ /
		Birth Date