

WELCOME TO OUR OFFICE



1350 Hamilton Street
Allentown, PA 18102
(610) 437-0330

TODAY'S DATE _____

Thank you for choosing our office.

In order to serve you properly we will need the following information. (Please print.) All information will be strictly confidential.

Patient's name		Birth date		Marital status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
Residence address		City	State	Zip	Home phone
If child, parent's name or guardian's name					
Name of employer		Address			Business phone
Social security number		Driver's license		Occupation	
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, how do you intend to pay? <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit card		Ins. co. name & address	
Subscriber name		Policy no.	Certificate no.	Is it through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of spouse		Birth date		Social Security number	
Is there secondary ins., spouse 2nd carrier, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name & address of spouse employer			Business phone
Secondary ins. name & address			Policy no.	Certificate no.	
Medicaid no.			Medicare no.		
Workmen's compensation			Name of company		
Address of company		Company phone		Treatment authorized by	
Person financially responsible for this account			Address		Relationship to Patient
Nearest friend or relative not residing with you			Relationship to patient		Phone
Whom may we thank for referring you?			Address		
What is your chief complaint?					

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature _____ Date _____