

<b>Today's Date:</b>
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Please complete this form in order to ensure proper billing of your services. **Please Print.**

Patient's Last Name		Patient's First Name		MI
DOB / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Race <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> Caucasian or White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Declined	
Ethnicity <input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Non-Hispanic or Non-Latino	<input type="checkbox"/> Unknown <input type="checkbox"/> Declined	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____				
Address Line 1		Address Line 2		
City			State	Zip
Home Phone		Daytime Phone		Cell Phone
Home E-mail				
Emp Status <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Other _____				
Employer			Work Phone	
Employer's Address Line 1		Employer's Address Line 2		
City			State	Zip

**Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)**

Guarantor's Last Name		Guarantor's First Name		MI
DOB / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Patient's Relationship to the Guarantor	Home Phone
Guarantor's Address Line 1		Guarantor's Address Line 2		
City			State	Zip
Guarantor's Employer				
Guarantor Employer's Address Line 1		Guarantor Employer's Address Line 2		
City			State	Zip

### Emergency Contact Information

Emergency Contact's Last Name		Emergency Contact's First Name		MI
Patient's Relationship to the Emergency Contact		Daytime Phone		Cell Phone

**Please select the source in which you heard of our practice**

<input type="checkbox"/> Billboard	<input type="checkbox"/> Brochure	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Health Plan	<input type="checkbox"/> Internet	<input type="checkbox"/> JEFF NOW®	<input type="checkbox"/> Mass Mailing	<input type="checkbox"/> Newspaper/Mag.	<input type="checkbox"/> Ongoing Care
<input type="checkbox"/> Patient	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Phys. Off./ER	<input type="checkbox"/> Relative	<input type="checkbox"/> Radio	<input type="checkbox"/> TV	<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> Other _____	

**Insurance Information** *A separate form is required for workers' compensation, automobile liability, or legal services.*

Primary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	
Secondary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	