Patient # ___________________

PATIENT INFORMATION Today's Date: _________________

PATIENT:
Name: ____ Birthdate: ___________________
(Last) (First) (M.)

Sex: __________ Marital Status: __________ SS # ______________________________

E-mail: ____

Mailing Address: ________________________ City ____________________ State__________ Zip ___________

Home Phone # (______) __________________________ Cell Phone #: (_______) ____________________________

Employer: ______________________________________ Work #: ___________________________ext. ______

Race: White, Black, Nat. Hawaiian, Alaskan Native, Pacific Islander, Decline
Ethnicity: Non-Hispanic, Hispanic, Decline
Is English your Primary Language? ____Yes ____No If no, what is? ____

Emergency Contact: ___________________________ Phone #: (_____) _______________ Relation: ____________
(Not same as home or work phone #, please)

I Authorize this office to verbally release medical information, including test results to: ___________________________

relationship: _______________________________ Phone #: ____

Who referred you to our office?____

DRUG ALLERGIES: ____

Spouse Name: ________________________ Birthdate: __________________ SS# : ________________________

Employer: ____ Phone # (____) ______________________

***** ***FOR MINOR AGED PATIENTS, PLEASE COMPLETE THE REVERSE SIDE ALSO ********
Other Family Members:

1. _______________________ Birthdate: __________________ Relationship: _________________________
2. _______________________ Birthdate: __________________ Relationship: __________________________
3. _______________________ Birthdate: __________________ Relationship: __________________________
4. _______________________ Birthdate: __________________ Relationship: __________________________

INSURANCE INFORMATION: *We will bill two (2) insurances for you.*

Primary:	Secondary:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:

** Please give your insurance card to the receptionist so copies can be attached to your chart. It is your responsibility to ensure that we have to most current insurance information on file for you.

The above information given by me is correct. I hereby authorize Dr. Knapp, DO PC to furnish information to insurance carriers concerning my illness and treatment. I assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amounts not covered by my insurance and that if office visit co-pays apply, they are to be paid at the time of service.

Signed by: ____ Date: ____________________________

Father:

Name: ____________________________ Birthdate: ___________________________ SS# ______________________

Address: _____________________________ City _________________________ State _______________ Zip _________

Home Phone: ___________________________ Employer: ________________________ Work # (_____) ____________

Mother:

Name: ____________________________ Birthdate: ___________________________ SS# ______________________

Address: __________________________ City _________________________ State _________________ Zip _________

Home Phone: __________________________ Employer: _________________________ Work # (_____) ____________

Non-Custodial Parent:

Name: ____

Address: ____

Does this parent also carry insurance on this child? If so, please provide information.