

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

_____ Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact _____

Restrictions: _____

Age _____ Birthdate _____ SS# _____ Sex _____

Marital Status Unspecified Spouse Name: _____ Other: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Watanabe to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Watanabe and myself.

Signature _____ **Date** _____