Doctor : **Date :**

Thank you for choosing our office. In order to serve you properly, please review and complete this form.

First, Middle, Last Name:	Maiden Name:	Chart #
Billing Address:	City/State/Zip:	County you live in:

Does the patient reside at a Nursing Home or an Assisted Living Facility? Yes or No

If yes, list which one and the phone #?

Birthdate:	Age:	SSN:	Marital Status:	Gender:	Race:
Home Ph:		Cell Ph:	Work Ph: Ext # :		
Email: (If you would like to receive information from our office please give us your email address.)			May we leave messages for you at home or on your cell phone or at work:		
Ethnicity (Nationality): **Please circle one.** **I am not Hispanic or Latino / I am Hispanic or Latino**			Preferred language spoken:		
Employer:		Occupation:		Full/Part/Student/Retired/Other:	
Spouse Name :			Spouse SSN :		
Spouse Employer :			Spouse Work Ph :		
Emergency Contact Name: *** (Someone other than spouse)**			Relationship:		
ER Contact Home Ph:			ER Contact Work Ph:		

Did a Doctor/ Provider recommend GBPSA for **today's** appointment? (Please circle) **Yes or No**

Doctor / Provider & Clinic Name:

Who is your Primary Care Doctor?	Primary Care Doctor Clinic Name: May we send a letter to your Primary Care Doctor?

How did you hear about us? Mark all that apply

Attorney☐ Newspaper Ad☐ Phone Book☐ Magazine☐ Insurance Company☐ Seminar☐

Spa☐ Web☐ I am an existing patient☐ Other:☐ _____

Primary Insured Party Name: Address: Relationship to patient:		Insured Party DOB: Insured Party SS #:	
Primary Ins:	ID #:	Group #:	Employer Name:
Secondary Insured Party Name: Address: Relationship to patient:		Insured Party DOB: Insured Party SS #:	
Secondary Ins:	ID #:	Group #:	Employer Name:
If Workers Compensation, treatment authorized by:		Claim #:	

I acknowledge that all of the above information is correct to the best of my knowledge.

Patient or Authorized Representative Signature: **Date:**