



PATIENT INFORMATION
WELCOME TO OUR OFFICE!
Please tell us who referred you.

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

Patient: _____ Responsible Party: _____
Email Address Email Address

How did you hear about Dr. Tipton? _____

Names and birthdates of other children in your family: _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Rent _____ Own _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

PRIMARY:

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Do you have dual coverage? Yes No If Yes, please continue: _____

SECONDARY:

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ **Date** _____

I understand that where appropriate, credit bureau reports may be obtained.