**In-Sync & Social** **Today's Date:** _____

# Patient Information Sheet

***** PLEASE COMPLETE ALL INFORMATION *****

| PATIENT DEMOGRAPHICS | |
|---|---|
| ***Patient's Name*** | **Date of Birth** |
| **Address** | **Soc Sec #** |
| | |
| ***Caregiver's Name*** | **Home Phone** |
| **Employer** | **Work Phone** |
| **Cell Phone** | **Soc Sec #** |
| **Email Address** | |
| ***Caregiver's Name*** | **Home Phone** |
| **Employer** | **Work Phone** |
| **Cell Phone** | **Soc Sec #** |
| **Email Address** | |

| MEDICAL INFORMATION |
|---|
| ***Diagnosis*** |
| |
| ***Reason for Coming Today*** |
| |
| |
| ***Primary Physician Information*** **(who is responsible for primary healthcare of child)** |
| **Physician Name** **Practice Name** |
| **Address** **Office Phone** |
| |
| ***Secondary Physician*** **(any other physician reports should be sent to)** |
| **Physician Name** **Practice Name** |
| **Address** **Office Phone** |
| |

| BILLING INFORMATION | |
|---|---|
| ***Person Responsible for Bills*** **(who is responsible for all unpaid balances, copays, and deductibles)** | |
| **Name** | **Phone** |
| **Address** | **Soc Sec #** |
| | |
| ***Insurance Information*** **(copy all information from your card and give the card to the front desk for copy)** | |
| **Primary Insurance Name** | **Policy ID #** |
| **Address** | **Group #** |
| | **Phone #** |
| **Cardholder's Name** | |
| **Relationship to Patient** | **Birthdate** |
| **Secondary Insurance** | **Policy ID #** |
| **Address** | **Group #** |
| | **Phone #** |
| **Cardholder's Name** | |
| **Relationship to Patient** | **Birthdate** |

| ***How did you hear about us?*** | |
|---|---|
| **Referring person/contact** | |
| **Address** | **Phone** |
| | |