THE CONRAD | PEARSON CLINIC

Patient Information
(please print)

Date _____
Acct. _____

PATIENT INFORMATION *(FULL LEGAL NAME)*

Name _____
(Last) (First) (Middle)

Address _____
(Street Address Only...No Post Office Boxes)

City _____ State _____ Zip _____

Home Phone _____ Cell # _____ Sex _____ Marital Status _____

Date of Birth _____ Age _____ Race _____ Ethnicity _____

Preferred Language _____ Social Security # _____

Employer's Name _____ Work Phone _____

Email Address

❑ **SPOUSE**
❑ **PARENT**
❑ **RESPONSIBLE PARTY**
INFORMATION

Name _____ Relationship _____

Address _____

City, State, Zip _____ Home Phone _____

Sex _____ Date of Birth _____ Social Security # _____

Employer's Name _____

Work Phone _____

EMERGENCY CONTACT

Name _____ Phone _____

INSURANCE INFORMATION

We will file your health insurance, however, you will receive monthly statements. At each visit, you are responsible for paying copayments, deductibles and any balance due after insurance has paid. You are responsible for promptly responding to all insurance inquiries.

Primary Carrier:

(Please provide us with a copy of your insurance card.)

Insurance Company Name _____

Insurance Company Address _____

City, State, Zip _____ Phone _____

Insured's Name _____ Insured's DOB _____

ID # _____ Group # _____

Preferred Lab _____

Secondary Insurance:

Insurance Company Name _____

Insurance Company Address _____

City, State, Zip _____ Phone _____

Insured's Name _____ Relationship _____

ID # _____ Group # _____

REFERRAL SOURCE

_____ Doctor _____ Friend _____ Other (Please let us thank your friend or doctor)

Name _____

Address _____ Phone _____

How did you hear about The Conrad Pearson Clinic?

☐ Another patient/individual ☐ WMC Health Links ☐ Internet ☐ Newspaper ☐ Radio

☐ Referring Physician ☐ TV Ad ☐ Self ☐ Other _____