

Today's Date _____

Patient Information

Name _____ Date of Birth _____ Age _____
last name first name m.i.

Address _____
street apt # city state zip

Mailing Address _____
If different than above city state zip

Home Phone () _____ Sex: M F Status: S M D W

Additional Information for PATIENT or Guardian (Required)

Name of responsible person if other than patient or if patient is a minor _____
 Relationship to Patient _____ Date of Birth _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____ E-Mail _____

Social Security # _____ Driver's License #/State _____

Place of Birth _____ Occupation _____

Emergency Contact Information

Name of Person to Contact _____
 Phone () _____ Relationship to Patient _____

Check here to authorize CEI to disclose your private health information to this individual

Insurance Information

Primary Insurance

Secondary Insurance (Courtesy only)

Insurance Co. Name _____
 Subscriber Name _____
 Subscriber I.D. # _____
 Group or Policy # _____
 Subscriber Date of Birth _____
 Relationship to Patient _____

Insurance Co. Name _____
 Subscriber Name _____
 Subscriber I.D. # _____
 Group or Policy # _____
 Subscriber Date of Birth _____
 Relationship to Patient _____

How Did You Hear About Us?

Reason for Consultation _____
 Referred By _____ Specialty _____
 Address _____ Phone () _____
 Or Yellow Pages Relative Friend Employee Event Other _____
 Who is your Primary Care Physician? _____
 Address _____ Phone () _____

Other

I would like to receive the Institute's newsletters and/or information about events via e-mail Yes No
 e-mail address _____

CEI may leave voice mail messages containing my Private Health Information on any of the Yes No
 phone numbers listed on this form

Language I would prefer reminder phone calls in _____