Fort Collins Headache Center

Patient Information

Patient Name: ____ Date:_____/_____/_______
Last First MI

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Preferred Name:____________________

☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Male ☐ Female

Social Security #: ______________________________ Birth Date:_________________________________

Phone (Home): _______________ (Work): _______________ Ext:______ (Cell):____________________

Address: ____
Street Apartment #

____
City State Zip Code

Email Address:_____________________________________

Emergency Contact Person:___________________________ Emergency Contact Phone:______________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Dental Office

☐ Yellow Pages ☐ Newspaper ☐ Postcard ☐ Other mailing ☐ Other_________________

Name of person or office referring you to our practice:____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _______________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): _______________ (Work): _______________ Ext:______ (Cell): ____________________

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _________________________________ Occupation: ___________________________

Address: ____
Street City State Zip Code

Insurance Information

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________________ SS or ID #: ____________________ Group #:_______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Minor ☐ Other__________________

Dental Insurance Company:__________________________ Dental Insurance Phone: ______________

Dental Insurace Co. Claims Address:____

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