Patient Information

Date: _____

Name:	Home Phone:	Cell Phone:
Is this your legal name? Yes ☐ No ☐	If not, what is your legal name?	Former Name:
Address:	City:	State: Zip:
SSN:	Date of Birth:	Your Current Age:
Sex: ☐ Male ☐ Female	Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered ☐	
Spouse Name:		Spouse Work Phone:
Driver's License #:	Number of Children:	Ages of Children:
Emergency Contact: (Relationship):	Phone:	Appointment Confirmation Phone:

EMPLOYER INFORMATION	
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Non-Employed	
Employer:	Employer Phone:
Job Title:	How Long Employed:

PRIMARY INSURANCE	
Insurance Company:	Insurance Phone:
Name of Insured:	Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent
Insured's Date of Birth:	Insured's Employer:
Policy # (or SSN):	Group #:
Referred By:	

As of January 1, 2007, Dr. Mallett is out of network with all insurance carriers. Payment is due in full at the time of service. Please provide the receptionist with your healthcare information when you check in. After your visit, a completed claim form and receipt will be provided for you to mail to your insurance company. You will be reimbursed directly for any benefits due.

Thank you for your cooperation in these matters. With your help, these policies will enable us to treat you and your family with efficient and quality care. This has always been, and remains, our foremost concern.

Charles B. Mallett, MD

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