



Family Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Name	Middle Name	Last Name	SSN/ID:
			DOB:
Patient/Child's Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female		SSN/ID:
			DOB:
Patient/Child's Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female		SSN/ID:
			DOB:
Patient/Child's Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female		SSN/ID:
			DOB:
Home Address	City	State	Zip
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip
Whom may we thank for referring you? Name: _____			
In case of an emergency who should be notified? Name: _____ Phone: _____			
Person Responsible For Account ~ <input type="checkbox"/> Check Here If Same As Above			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number:			Date of Birth:
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Dental Insurance Information

<input type="checkbox"/> Check here if you do not have Dental Insurance			<input type="checkbox"/> Check here if you provided an insurance card to be on file		
Insured's First & Last Name		Date of Birth	Social Security		
of Insured's Employer			Patient Relationship To Insured		
Insurance Company		Phone	Subscriber ID #		Group ID #
Insurance Company Address		City	State	Zip	

Hippa Acknowledgement: Please Initial _____ I understand that I can ask and receive a copy of this office's Notice of Privacy practices.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr Lloyd all insurance benefits, and assign directly to Dr Lloyd all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

Dr Lloyd may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will stay in effect until patient revokes consent verbally or in writing. It immediately ends when patient discontinues services at our practice.

Signature of patient/parent/guardian _____

Print Name: _____

Date: _____