Align Clinic, LLC

PATIENT INFORMATION FORM

Section 1 – Patient Information

Patient Name:_____ _____ _____ Date of Birth:_____
First MI Last

Home Address:_____Apt#_____City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

E-mail Address:_____

Sex: ☐ Male ☐ Female Height:_____ Weight:_____ Marital Status:_____ SSN:_____

Emergency Contact Name:_____ Phone:_____

How did you hear about us?_____

Section 2 – Parent / Guardian / Financially Responsible Party / Primary Insurance Subscriber

Name:_____ Date of Birth:_____ SSN:_____

Relationship to Patient:_____ Phone (if different from above):_____

Employer: _____

Primary Insurance Provider:_____

Insurance ID Number:_____Group Number:_____

Secondary Insurance Provider:_____

Insurance ID Number:_____Group Number:_____

Section 3 – Medical Information

Diagnosis:_____ Date of Injury:_____

I certify that the information provided above is accurate and complete.

_____ _____
Signature of Patient/Responsible Party Date