

# Welcome

To the office of  
Dr. Richard Francis, Dr. Dale Hadley  
&  
Dr. Kyle Marshall

## Personal Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Gender:  Male  Female

First Mil Last Preferred

Minor  Single  Married  Divorced  Separated  Widow Spouse name \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

E-mail Address \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Whom my we thank for referring you to us? \_\_\_\_\_

## Responsible Party

(If different from above)

Name \_\_\_\_\_ Relation to Patient:  Parent  Self Other \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_ Gender: Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

E-mail address \_\_\_\_\_ Drivers License Number \_\_\_\_\_

## Employment Information

The following is for the:  Patient  Responsible Party

Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Insurance Information

Primary	Secondary
Name of Insured _____	Name of Insured _____
Birth Date _____	Birth Date _____
Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Insurance Plan _____	Insurance Plan _____
Employer _____	Employer _____
ID # _____	ID # _____
Group # _____	Group # _____
Insurance plan address _____	Insurance plan address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____