5060 Cascade Rd. Suite E, Grand Rapids, MI 49546
5131 East Paris Ave, Kentwood, MI 49512
Phone: 616-940-4647
Fax: 616-942-2497

(Please Fill Out Completely)

Last Name: _________________ First Name: _______________________ Date of Birth:____________

Address: ____________________________ City: _________________State: ______Zip:____________

Home Phone: (___) _______________Cell Phone: (___) ___________Work Phone :(__) ____________

Do you prefer to receive calls at: □ Home □ Work □ Cell □No Preference

Would you like to receive appointment reminders via text message? □ Yes □ No

Cell phone provider □AT&T □Sprint □T-Mobile □Verizon □Other _______________

E-Mail Address: ______________________________

Social Security #:_____________________ Age: __________ □ Male □ Female

Marital Status: □ Married □ Widowed □ Single

Name of Spouse or Nearest Relative: ________________________ Phone: __________________

Patients Employer/School: ________________________ Occupation: ______________________

Whom may we thank for referring you to us? : ____

Responsible Party

Name of person responsible for this account: ____

Relationship to patient____________________________ Phone: (___) ______________________

Address: ___________________________ City: ______________ State: ______Zip: __________

Insurance Information

Name of Insurance Co.:______________________ Insured's Employer: _________________
Insured's Name: ___________________________ Insured's Date of Birth: _______________
Contract/Member ID#:___________________________ Group #:______________________

Are you covered by more than one insurance company? □Yes □ No
If yes:
Name of Insurance Co.:______________________ Insured's Name:____________________
Insured's Date of Birth:__________________ Contract/Member ID#:__________________

Medical Information

Primary Care Physician: ____

Address: ____

Phone Number: (____)_________________

Date of last physical: __________