



Welcome...

Thank you for selecting Dr. Nielson!

To help us meet all of your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help you.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____
Soc. Sec. # _____ Birthdate _____ Home Phone _____ Cell _____
Address _____ City _____ State _____ Zip _____
Mark Appropriate: Minor ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed ___
Student, Name of College _____ City _____ State _____ Zip _____
Employer (Patient or Parent) _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Spouse Name _____ Employer _____ Work Phone _____
Parents Name _____ City _____ State _____ Zip _____
Person to contact in Case of Emergency _____ Phone _____
Whom May we Thank for Referring You? _____

Responsible Party

Relationship _____

Name of Person Responsible for this Account _____ to Patient _____
Address _____ Home Phone _____ Cell _____
Drivers License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SSN# _____
Is this Person Currently a Patient in our Office? Yes ___ No ___

PAYMENT IS TO BE PAID IN FULL AT TIME OF APPOINTMENT

For Your Convenience, we offer the following methods of payment

Please check the option you prefer. Cash ___ Personal Check ___ Credit Card ___ I wish to discuss the office's payment policy ___

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security# _____ Date Employed _____
Name of Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance

Name of Insured _____ Relationship to Patient _____ Insur. Co. _____
Birthdate _____ SS# _____ Insur Co. Address _____ Phone _____

Please turn over and complete other side