

AAAC Physician: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_  
 (address) \_\_\_\_\_  
 \_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_ County: \_\_\_\_\_  
 \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ CellPhone: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Student Status(y/n): \_\_\_\_\_  Veteran  Smoker  
 Email: \_\_\_\_\_ Language: \_\_\_\_\_  
 Ins. Company: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
 Primary Care Dr: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer(if patient is a minor this does not apply)  
 Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? YES  NO   
 IF THE ANSWER IS YES PLEASE GIVE THE PATIENT'S NAME: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

IF THE PATIENT IS A MINOR, the parent the child lives with is the responsible party:  
 Responsible Party: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Emp Telephone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

**SPOUSE INFORMATION OR OTHER PARENT**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

**INSURED INFORMATION**

Patient's Relationship to Insured(Spouse, Child, Dependent, Other): \_\_\_\_\_  
 If 'Other' Please Specify: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_