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823 Broad Street, Durham, N.C. 27705

**Which doctor are you scheduled to see today?** Dr. Heinly, Dr. Etter, Dr. Higgins

*Who Referred You To Us?* \_\_\_\_\_

Mr. Mrs. Ms. \_\_\_\_\_  
last first middle

Address: \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: M F Your SS#: \_\_\_\_\_

Marital Status: Married/ Single/Other Student Status: Full time or Part time

Employment Status: Full-time/Part-time/Unemployed/Retired

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

**Person Responsible for Payment** (if not the patient): \_\_\_\_\_

Their address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**In case of emergency notify:** \_\_\_\_\_  
Name relationship

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

**INSURANCE INFORMATION:** *We must have copies of your insurance cards*

**Primary Insurance Co:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured's Relationship to you: \_\_\_\_\_

**Secondary Insurance Co:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured's Relationship to you: \_\_\_\_\_

**Tertiary Insurance Co:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured's Relationship to you: \_\_\_\_\_