PINKER AND ASSOCIATES
47 Brookwood Avenue
Carlisle, PA 17015-9126
Telephone: 717-243-2236
Fax: 717-243-6536

WELCOME TO OUR OFFICE: In order that we may be better able to assist you in filing your claims, please answer as many of the questions as possible.

TODAY'S DATE: _____

Patient Name: _____ **Date of Birth:** _____ **Age**:_____ **Sex:** M / F

Marital Status: M / S / D / W **Patient's Social Security Number:** _____

Address:_____ **City/State/Zip:** _____

Home Phone #: (___) ____-_____ **Cell Phone #:** (___) ____-_____ **Email:**_____

Race: □ **White** □ **Black/African American** □ **American Indian/Alaska Native** □ **Asian**
□ **Native Hawaiian/Other Pacific Islander** □ **Patient Declined/Unknown** □ **Other** _____

Ethnicity: □ **Spanish/Hispanic Origin** □ **Not of Spanish/Hispanic Origin** □ **Patient Declined/Unknown**

Primary Language: □ **English** □ **Other** _____

Place of Employment: _____ **Work Phone #:** (___) ____-____ **Ext.:**_____

Spouse's Name: _____ **Work Phone #**: (___) ____-_____ **Ext.:** _____

EMERGENCY CONTACT : _____ **Phone #:**(___) ____-_____

RELATIONSHIP OF CONTACT PERSON: _____**FAMILY DOCTOR:** _____

***** **GUARANTOR** **: (*Please complete if the patient is under 18 years of age or if someone other than the patient is responsible for the bill*).**

Name: _____ **Relationship to Patient:** _____

Address:_____ **City/State/Zip:** _____

Home Phone #: (___) ____-_____ **Cell Phone #:** (___) ____-_____

Place of Employment: _____ **Work Phone #:** (___) ____-____ **Ext.:**_____

INSURANCE: (*Please provide cards*)

*** PRIMARY INSURANCE COMPANY:** _____

Employer: _____

Subscriber: _____ **Subscriber's DOB:** _____

Relationship to Patient: _____

*** SECONDARY INSURANCE COMPANY:** _____

Employer: _____

Subscriber: _____ **Subscriber's DOB:** _____

Relationship to Patient: _____