DRS. BORDERS, HOOD & ASSOCIATES

PATIENT QUESTIONNAIRE

BOR-14 (Rev. 1-15-10)

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Sex M F	Social Security #	Marital Status

Address

City	ST	Zip

Home Ph #	Work Ph #	Cell Ph #

Patient Email	Employer Name
Referring Physician	Primary Care Physician

FINANCIALLY RESPONSIBLE

Name

Address

City	ST	Zip

PRIMARY INSURANCE INFORMATION

Policy ID #	Plan Name

Effective Date	Policy Holder Name	Date of Birth

Group #	Policyholder Relationship

SECONDARY INSURANCE INFORMATION

Policy ID #	Plan Name

Effective Date	Policy Holder Name	Date of Birth

Group #	Policyholder Relationship

GENERAL INFORMATION

Occupation	Whom may we thank for referring you?

IN CASE OF EMERGENCY

Please notify (nearest relative not living with you) - Name

Address	City	ST	Zip

Home Phone	Daytime Phone	Relationship

Signed: _____ Date: _____