PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ______________________ (First) ___________ (MI) _____ Previous Name ________________

Address Line 1 ____

City, State ____________________________ ZIP__________ Pharmacy____________Pharmacy Phone_____________

Home Phone ____________________ Cell No. __________________ Work Phone _______________Ext. __________

Primary Care Provider (PCP) ______________________________ Referring Provider ________________________

Rendering Provider Name (this practice) ___________________________ E-Mail Address:____________________

Date of Birth MM ______/DD ________/YYYY ___________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other __________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-______-________ Employer Name ______________________________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ______________________________ First Name ____________________

Phone Number ____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____________________________________ ☐ Guardian

Referring Provider Name ____

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ______________________ (First) _____________________ (MI) __________

Guarantor Account Number _______________________ Date of Birth MM ________/DD ________/YYYY __________

Social Security Number _______-______-________ Telephone ____________________

E -Mail Address ______________________________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State ____________________________ ZIP _________________

Employer____ Employer Phone Number__________________

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_______________________________________ (______)_____________

Name of Insured_________________________________ Patient Relationship to Insured_________________

Subscriber ID (Policy Number)_________________ Group ID_______________ Copay Amount_______________

Effective Date____________________ Termination Date______________ Date of Birth MM ______/DD ______/YYYY _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_______________________________________ (______)_____________

Name of Insured_________________________________ Patient Relationship to Insured_________________

Subscriber ID (Policy Number)_________________ Group ID_______________ Copay Amount_______________

Effective Date____________________ Termination Date______________Date of Birth MM ______/DD ______/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***______________

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