

Today's Date: _____

Personal Information

Name: _____

Date of Birth: _____ Social Security Number: _____

Physical Address: _____

Mailing Address: _____

City & State: _____ Zip Code: _____

Phone #: Home: _____ Work: _____

Cell: _____ Other: _____

Email address: _____

Occupation: _____ Employer: _____

Marital Status: Single Married Widowed Divorced Other

Referred by: _____

Your Preferred Pharmacy: _____

Spouses, Guarantor or Significant Other Information

Name: _____

Date of Birth: _____ Social Security Number: _____

Occupation: _____ Employer: _____

Phone #: Home: _____ Work: _____ Cell: _____

May we disclose health/billing information to this person? Yes No

Other than my spouse, guarantor or significant other, I give permission for the following individual(s) to be able to discuss my chart/billing with either the doctor, nurse or office staff.

Emergency Contact Information: (Parent, nearest relative or friend someone not living with you)

Name: _____ Relationship: _____

Address: _____

City & State: _____ Zip Code: _____

Phone#: Home: _____ Cell: _____

Insurance Information

Primary: _____ Secondary: _____

ID#: _____ ID#: _____

Group#: _____ Group#: _____

Subscriber: _____ Subscriber: _____

Authorization to release medical information to insurance company or another physician care for patient. I realize, I am responsible for all charges regardless of insurance. I hereby authorize my insurance benefits to be paid directly to the undersigned physician.

Patient's Signature: _____