

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address (Street or PO Box) \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Gender Male  Female

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status Married  Single  Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact (non-family member, outside of your home) Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

SPOUSE/GUARDIAN Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address (Street or PO Box) \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### INSURANCE INFORMATION

How do you intend to pay for your visit? Cash  Check  Credit Card  Insurance

Primary Health Insurance Company: \_\_\_\_\_

Mailing Address \_\_\_\_\_

Policy or ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insured Name \_\_\_\_\_ Relationship to insured: Self  Spouse  Child

### PREFERRED PHARMACY INFORMATION

Mail order Pharmacy if applicable \_\_\_\_\_

Local Pharmacy name & phone number \_\_\_\_\_

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes the release of any medical or other information necessary to process this claim.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Printed name and relationship to patient if signature is not Patient