PATIENT INFORMATION

PATIENT NAME _____

STREET ADDRESS _____

CITY_____STATE_____ ZIP_____HOME PHONE_____

WORK PHONE_____ CELL PHONE_____

PREFERRED CONTACT, CIRCLE ONE: HOME WORK CELL DATE OF BIRTH_____

SSN#_____ MARITAL STATUS: M S D W SEP. SEX: M OR F

PRIMARY CARE PHYSICIAN _____RACE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE_____

PREFERRED PHARMACY_____CITY/STATE_____

EMERGENCY CONTACT PERSON_____RELATIONSHIP_____

HOME PHONE_____WORK_____

EMPLOYMENT INFORMATION

PATIENT'S OR PARENT'S EMPLOYER_____

INSURANCE INFORMATION (WE WILL TAKE A PICTURE OF YOUR CARD)

PRIMARY INSURANCE _____

NAME OF EMPLOYER _____

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

ID#_____DATE OF BIRTH_____

SECONDARY INSURANCE _____

NAME OF EMPLOYER _____

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

ID#_____DATE OF BIRTH_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____DATE_____