Patient Information

PLEASE PRINT

|  |  |  |  |
| --- | --- | --- | --- |
| Appt. Date/Time: | Appt. Dr.: | PCP: | Account No: |

Demographic Information

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name: | M.I.: |
| Address: | Date of Birth: | Age: | Sex: |
| City, State, Zip: |
| Social Security No: | Marital Status: |
| Home Phone: | Work Phone: |
| Cell Phone: | Email: |
| Employer Name: | Employer Address: |
| Preferred Pharmacy:  | Address: | Phone: |
| Race: American Indian Asian African American Caucasian Hispanic Other Do not wish to report |
| Ethnicity: Hispanic Non-Hispanic Do not wish to report |
| Language: |  |

Insurance Information

Please give your insurance card(s) to the person at the front desk.

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| --- |
| Person responsible for the bill: |
| Address (if different from patient): |  |
| Home Phone: | Is this person a patient here? Yes No  |
|  |  |
| Primary Insurance: | Subscriber’s Name: |
| Subscriber’s Date of Birth: | Subscriber’s Social Security No: |
| Policy No.: | Group No.: |  |
| Patient’s Relationship to Subscriber: |
|  |
| Secondary Insurance: | Employer: |
| Subscriber’s Date of Birth: | Subscriber’s SSN: |
| Policy No.: | Group No.: |  |
| Patient’s Relationship to Subscriber: |

In Case of Emergency

|  |  |  |
| --- | --- | --- |
| Emergency Contact: |  |  |
| Relationship to Patient: | Contact Phone: |  |
| Signature:  | Date: |