

**PATIENT INFORMATION**

*(Please Print)*

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
Last First M.I.

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Area Code Area Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Lic# \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_ Dominant Hand Left  Right

**RESPONSIBLE PARTY** *(if different from patient)*

Name \_\_\_\_\_  
Last First M.I.

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Area Code Area Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**INSURANCE INFORMATION** *(Please present insurance card at time of check in.)*

Primary Insurance Co. \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_  
Area Code

Secondary Insurance Co. \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_  
Area Code

Other family members that are patients \_\_\_\_\_

Pharmacy of choice \_\_\_\_\_ Phone \_\_\_\_\_

In case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date of last physical \_\_\_/\_\_\_/\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Updated By: \_\_\_\_\_