

Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_  
Contact Drivers License # \_\_\_\_\_  
Restrictions: \_\_\_\_\_ (include State)

Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ Phone No \_\_\_\_\_

**Patient's Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_  
Street & Suite # City State Zip

**Emergency Contact**  
(Not in your household) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street & Apt # City State Zip

**Primary Health Insurance Company** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

**Insured:** Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Health Insurance Company** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

**Insured:** Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_