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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: |