



## 1. Personal Information

Name \_\_\_\_\_  
First Name Middle Initial Last Name

Street Address \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_

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

Employer's Address \_\_\_\_\_

In Case of Emergency, Notify:  
 Name \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Relationship To Patient \_\_\_\_\_

Is This Your First Visit To Our Office? \_\_\_\_\_ Referred By \_\_\_\_\_

## 2. Insurance Information

(If you are employed and have insurance with your employer, your insurance is the PRIMARY Insurance Company)

**Do You Have Health Insurance?**       **Yes – If Yes, See Below**       **No**

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

Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Please complete if NOT printed on ID CARD)

Policy Holder Name \_\_\_\_\_ Relationship To You: Self / Spouse / Parent / Other: \_\_\_\_\_  
(If other than patient)

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

Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Please complete if NOT printed on ID CARD)

Policy Holder Name \_\_\_\_\_ Relationship To You: Self / Spouse / Parent / Other: \_\_\_\_\_  
(If other than patient)

**\*\*\*Your Preferred Pharmacy\*\*\***

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

## 3. Authorization & Contact Information

*I agree that I am responsible for payment of all services rendered on my behalf. If I have insurance coverage, I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for my insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the provider.*

\_\_\_\_\_  
**Patient Signature or Responsible Party**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Date Signed**

**Patient Home Phone#** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

*What Hours?* \_\_\_\_\_

**Patient Work Phone#** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

*What Hours?* \_\_\_\_\_

**Patient Cell Phone#** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Email Address \_\_\_\_\_