Doctor:

PATIENT INFORMATION

Name:

Address:

City,State, Zip:

Phone:[ ]Home [ ]Work [ ]Other

Phone:[ ]Home [ ]Work [ ]Other

Phone:[ ]Home [ ]Work [ ]Other

Patient ID #: Sex [ ]M [ ]F

Date of Birth: Age:

Social Securitv #:

Race:

Ethnicity: [ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other

Preferred Language:

Marital Status: [ ]Married [ ]Single [ ]Divorced

Email Address:

Referring Physician:

Primary Physician:

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name:

Employer's Phone:

Occupation

EMERGENCY CONTACTS

Name Relationship Phone

RESPONSIBLE PARTY (If patient is under 18 years of age)

Name:

Address:

City,State, Zip:

Employer:

Home Phone:

Work Phone:

SSN:

Date of Birth:

PRIMARY INSURANCE

Insurance Company Name:

ID #:

Group/Policy #:

Subscriber's Name:

Subscriber's Phone #:

Relationship to Patient:

Subscriber's Employer:

Subscriber's SS #:

Subscriber's Date of Birth:

SECONDARY INSURANCE

Insurance Company Name:

ID #:

Group/Policy #:

Subscriber's Name:

Subscriber's Phone #:

Relationship to Patient:

Subscriber's Employer:

Subscriber's SS #:

Subscriber's Date of Birth:

WORK RELATED INJURY *Only applicable if injury is related to work or auto accident*

Insurance Carrier Name: Address:

City, State, & Zip: Phone:

Claim Number: Date of Injury: Employer @ time of Injury:

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT/GUARDIAN SIGNATURE DATE