Patient Information

Name____ Birthdate ____________________S.S. #______________________
Last Name First Name Initial

Address____

City____ State________ Zip_______________ Home Phone _____________________

Cell Phone__________________________ Email Address ____ Sex ☐ M ☐ F

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: ☐ African American ☐ Alaska Native ☐ Asian ☐ Other ☐ Native American ☐ Native Hawaiian ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown **Primary Language** ______________________

How did you hear about us: ☐ Word of Mouth ☐ Website ☐ Insurance Company ☐Other Physician's Office

☐ Phone Book -If phonebook please indicate which one: ____ Yellow Book _____ Red Book _____ Alltel Phonebook

☐ If other source please list here____

Notify in case of emergency____ Relationship______________________

Home Phone____ Cell Phone____

Patient Employed by____

Business Address____

City____ State______ Zip___________ Business Phone ___________________________

Insurance Information

*Please give our receptionist an updated copy of your insurance card(s).
Co-Pays and Co-Insurance are due at time of service.*

Primary Insurance

Primary Insured____
Last Name First Name Initial

Relation to Patient_______________________________________ Birthdate____________________ S.S.#__________________________

Address (if different from patient)____ _____ Phone_______________________

City____State_________ Zip______________________

Person Responsible Employed by____ Business Phone _____________________

Insurance Company____ Phone____________________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No (If yes please give us copy of insurance card.)

Preferred Pharmacy ____________________________ Address ____