

Account No:

DEMOGRAPHIC INFORMATION

First Name:		Last Name:		MI:
Preferred or Nickname:		Maiden Name:		DOB: mm/dd/yyyy
SSN:		Marital Status (Circle One) Married Single Widow Divorced		
Sex:		Primary Language:		
Address:		Apt/Unit:	City:	
State:	ZIP:	County:		
Is this your primary address? Y / N (If not please provide further information)				
Employer:		City, State:		
Race: (Circle One) African American/Black American Indian/Alaskan Native Asian Caucasian/White Declined Nat Hawaiian/Pacific Islander Other Race Unknown				
Ethnicity: (Circle One) Declined Hispanic or Latino Not Hispanic or Latino Unknown				

CONTACT INFORMATION

Place a check in the box next to your primary phone number:	Home: <input type="checkbox"/>	Work: <input type="checkbox"/>	Cell: <input type="checkbox"/>
Email Address:			
What is your preferred method of communication for appointment reminders? (Circle One)	Phone	Email	Text
			Declined

PHARMACY AND PROVIDER INFORMATION

What is your preferred Pharmacy?	Pharmacy Phone:
Approximate Location: (City, cross street, etc.)	
Referring Doctor:	Primary Care Doctor:

EMERGENCY CONTACT

Name:	Relationship:	DOB: mm/dd/yyyy	Phone:
Do you have a Living Will? Y / N	Do you have Power of Attorney for healthcare? Y / N		

How did you hear about us? Physician Family/Friend Health Plan Website/Internet Seminar/Lecture Student Health ER Other

INSURANCE/BILLING INFORMATION Please fill out only if you do not have your insurance card with you.

Primary Insurance	
Primary Ins:	Policy ID#:
Policy Holder:	Group#:
Policy Holder Relationship to Patient:	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	Address? (If not the same as patient)
Secondary Insurance	
Secondary Ins:	Policy ID#:
Policy Holder:	Group#:
Policy Holder Relationship to Patient:	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	Address? (If not the same as patient)

Patient Signature: _____ Date: _____