Patient Information**********

Please Print

Last Name: First Name: Middle: Maiden Name:

_____ _____ _____ _____

Date of Birth: Gender Social Security # Marital Status
____/____/____ Male or Female _____/_____/_____ □ Married □ Single □ Divorced □ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Phone (H):_____ Phone (Cell): _____

Driver License No: _____ Date Expired: ____/_____/_____ State Issued: _____

Responsible Party :
(Name of Responsible Party for this account)
Last Name: First Name: Middle: Maiden Name:
_____ _____ _____ _____

Date of Birth: Gender Social Security # Marital Status
____/____/____ Male or Female _____/_____/_____ □ Married □ Single □ Divorced □ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Phone (H):_____ Phone (Cell): _____ Relation: _____

Driver License No: _____ Date Expired: ____/_____/_____ State Issued: _____

Insurance Company:
(Please present Receptionist with your insurance card)

Name of Primary Insurance: _____ Group #: _____ Policy #: _____

Policy Holder: _____ Relationship to Policy Holder: □ Self □ Child □ Spouse □ Other _____

Employed by: _____□ Not employed □ Student □ Full-time employee □ Part-time □ Other

Do you have any additional insurance? □ Yes □ No
Name of Secondary Insurance: _____ Group #: _____ Policy #: _____
Policy Holder: _____ Relationship to Policy Holder: □ Self □ Child □ Spouse □ Other_____
Employed by: _____ □ Not employed □ Student □ Full-time employee □ Part-time □ Other

Name of Tertiary Insurance: _____ Group #: _____ Policy #: _____
Policy Holder: _____ Relationship to Policy Holder: □ Self □ Child □ Spouse □ Other _____
Employed by: _____ □ Not employed □ Student □Full-time employee □ Part-time □ Other

Emergency Contact:
(Please fill out attached form "Release Consent" to be able to release information to Emergency Contact)

Last Name: First Name:
_____ _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (H):_____ Phone (Cell): _____ Relation:_____

Signature: _____ **Date: _____/_____/_____**

Office Use Only:

_____ _____
Pharmacy

_____ _____
Provider's Name **Information taken by:**