# PATIENT INFORMATION

# DEMOGRAPHICS

## PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ______

Occupation: ______________________________

Employer: ______________________________

Employers Address and Phone#: ____________

______________________________

Pharmacy Name and Address: ____________

______________________________

Pharmacy Phone: ______________________

Date of Birth: ____________ Age: _______

Sex: M F • Married: Y N • Partner: Y N

Marital/Partners Name: ________________

______________________________

Email: ______________________________

Social Security #: ______________________

Driver's License #: ____________ State: ____

Mobile Phone: ______________________

Home Phone If Different: ________________

Work Phone: ______________________

## RESPONSIBLE PARTY INFORMATION (If different)

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ______

Email: ______________________________

Relationship To Patient: ________________

Mobile Phone: ______________________

Home Phone If Different: ________________

Work Phone: ______________________

## HEALTH INSURANCE (Please give your insurance cards to the receptionist)

Insurance Co: ______________________

Address: ______________________________

City: ____________ State: ____ Zip: ______

Effective Date: ________ Through: ________

Phone: ______________________________

Plan Name: ______________ Copay: $______

Policyholder's Name: ________________

Relationship To Patient: ________________

Policyholder's DOB: ________________

Policyholder's SSN: ________________

Policyholder's Employer: ________________

Policy #: ______________________________

Group #: ______________________________

## ADDITIONAL SECONDARY INSURANCE

Insurance Co: ______________________

Policyholder's Employer: ________________

Policy #: ______________________________

Group #: ______________________________

Policyholder's Name: ________________

Relationship To Patient: ________________

Policyholder's DOB: ________________

## IN CASE OF AN EMERGENCY

Notify: ______________________________

Home Phone: ______________________

Relationship To Patient: ________________

Work Phone: ______________________

## SIGNATURE

The undersigned verifies that the above information is true and correct:

Signature: ______________________________________________ Date: ____________

(If the patient is a minor – signature of parent or guardian)