PATIENT INFORMATION

Patient's Name (Last, First, Middle)______________________________________

In order to comply with new health care reform initiatives, we are required to ask your ethnicity and language.

American Indian or Alaska Native *Asian* *Black or African American*

Hispanic/Latino *Native Hawaiian* *White* *Declined*

What is your preferred language? ______________________________Gender: M / F

Birth date ______________________Social Security______________________

Address____

City______________________ State__________ZIP______________________

Cell ______________ Home Phone______________ Work Phone______________

Responsible party Name______________________ Birthday ______________________

Phone______________________ May we leave a message at your home number? □ Yes □ No

Patient portal access and reminders - email address ______________________

INSURANCE INFORMATION

Insurance Name / Policy Holder's Name__________________ / __________________

Policy Holder's Birth date______________________ Social Security ______________________

Policy Holder's relationship to the patient ______________________________

Insurance ID Number ______________________Group Number ______________________

WHICH PHARMACY DO YOU PREFER?

1st Pharmacy Name __________________ Est. Address ______________________

2nd Pharmacy Name __________________ Est. Address______________________

Mail Order Pharmacy __________________ Phone______________________

EMERGENCY CONTACT INFORMATION

Please give the names of two nearest relatives not living with you:

Name ____

Relationship ______________________ Phone ______________________

Name ____

Relationship ______________________ Phone ______________________

I certify that the information I have given on this sheet is true and correct. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for all services rendered in this office. If I have insurance coverage, it is my responsibility to make sure that the insurance company pays. Also, I understand that should collection action become necessary, the responsible party agrees to pay additional 35% collections fees, and all legal fees, including attorney's fees and court costs.

______________________________ ______________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

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PLEASE PRINT PATIENT NAME