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Patient Information

(Please print clearly)

Patient's Name (Last) _____ (First) _____ (MI) ____
Nickname_____ Email_____
Sex □ M □ F Date of Birth ___/___/____ SS # _____
Address _____ APT #_____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work _____
Primary Language* _____ Marital Status: M / S / D / W *(please circle)*
Race* _____ Ethnicity* Hispanic or Latino/ Not Hispanic or Latino *(please circle)*

* Requested under federal guidelines for "Meaningful Use" to optimize patient-specific treatment and counseling

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Emergency Contact _____ Relationship_____ Phone _____
May we discuss your medical condition with another person? □ Yes □ No
If Yes, Whom _____ Relationship_____
Primary Care Provider _____ Phone _____
Did a doctor refer you to us? If yes, Doctor _____ Phone _____
Preferred Pharmacy _____ Location_____
How did you hear about us? _____

Responsible Party *(Complete only if the patient is a minor/dependent)*
Guarantor Name _____ Relationship to Patient _____
Home Phone _____ Cell Phone _____ Work _____
Address _____ APT #_____
City _____ State _____ Zip _____
Guarantor SS # _____ Guarantor DOB ___/___/____ Sex □ M □ F

* We do not bill absent parents; the adult presenting the patient for care is the responsible party.

I hereby certify the above information to be true and correct to the best of my knowledge. I understand that I am responsible to pay for all services rendered to me, I grant permission to my physician to mutually exchange medical information with referring physician and/ or associates. I hereby authorize disclosure of my medical records to my insurance carrier to obtain reimbursement.

Signature: _____ Date: _____