CONFIDENTIAL PATIENT INFORMATION

Last Name	First Name	MI	Birth Date	Today's Date	Patient Acct

Address	City	State	Zip Code	MRN

Home Phone: Work Phone	Mobile Phone:	Gender	Social Security #

Language:
Please select one:

□ English □ Spanish □ French □ Arabic □ Chinese □ German □ Greek □ Italian □ Japanese □ Korean □ Mandarin □ Persian □ Vietnamese □ Tagalog □ Russian □ Cambodian □ Laotian □ Other

Race:
Please select one race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Declined to answer
□ Unknown

Additional Race:
Please select one additional race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Declined to answer
□ Unknown

Ethnicity
Hispanic or Latino- *A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race.* ***Please select:***

□ Hispanic or Latino □ Non-Hispanic or Latino
□ Decline to answer □ Unknown

Marital Status:

Email:

Emergency Contact	Phone Number	Relationship to Patient

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name	First Name	MI	Relationship to Patient	

Address	City	State	Zip Code

Home Phone: Work Phone:	Social Security #	Birth Date	Gender

Employer's Name	Preferred Pharmacy:

Insurance Name:		Insurance Name:	
Claims Address	CoPay	Claims Address	CoPay
City, State, Zip	Ins Ph. No.	City, State, Zip	Ins Ph. No.
Subscribers Name	Gender M ☐ F ☐	Subscribers Name	Gender M ☐ F ☐
Subscribers ID	PCP	Subscribers ID	Group No. **«PL2GroupNo»**
Subscribers Birth Date	Effective Date	Subscribers Birth Date	Effective Date

Patient's Relation to Subscriber:	Patient's Relation to Subscriber:
Self Spouse Child Other	Self Spouse Child Other

PRIMARY INSURANCE SECONDARY INSURANCE

I authorize payment of my medical benefits be made directly to my physician for services rendered. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information necessary related to my medical care and to facilitate payment of my medical expenses owed my physician.

_____ _____

SIGNED (Insured or Authorized) ***DATE***