	DATE	NEW ❑ UPDATE ❑
PRIMARY CARE PROVIDER	PHARMACY NAME	
REFERRED BY	PHARMACY PHONE	
	HIPAA AUTHORIZATION CODE	

PATIENT INFORMATION

Acct Number

PATIENT SOCIAL SECURITY #

LAST	FIRST	MI.	BIRTHDATE	SEX M ❑ F ❑
ADDRESS	CITY	STATE	ZIP	MARITAL STATUS

HOME PHONE	WORK PHONE
CELL PHONE	EMAIL ADDRESS

RACE ❑ AMERINDIAN ❑ BLACK ❑ HISPANIC ❑ ASIAN ❑ WHITE

ETHNICITY ❑ HISPANIC ❑ NON-HISPANIC | PREFERED LANGUAGE:

EMPLOYER/SCHOOL	OCCUPATION			
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

NEXT OF KIN/EMERGENCY CONTACT (PERSON NOT LIVING WITH YOU)	RELATIONSHIP	PHONE

PARENT/GUARANTOR INFORMATION- PERSON FINANCIALLY RESPONSIBLE FOR BILL

LAST	FIRST	MI.	❑ PARENT (IF PATIENT A MINOR) ❑ SPOUSE ❑ OTHER ____________________	BIRTHDATE
ADDRESS (IF DIFFERENT FROM PT.)	CITY	STATE	ZIP	SOCIAL SECURITY #

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

EMPLOYER/SCHOOL	OCCUPATION			
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

INSURANCE INFORMATION

Please complete all information to ensure accuracy in claim submission

INSURANCE COMPANY #1	POLICY/MEMBER ID #	GROUP #		COPAYS SPEC - $ PRIM - $
POLICY HOLDER DOB	ADDRESS (IF DIFFERENT) CITY	SSN ST	ZIP	RELATION TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER
INSURANCE COMPANY #2	POLICY/MEMBER ID #	GROUP #		COPAYS SPEC - $ PRIM - $
POLICY HOLDER DOB	ADDRESS (IF DIFFERENT) CITY	SSN ST	ZIP	RELATION TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

INJURY INFORMATION

IS INJURY ❑ WORK RELATED ❑ AUTO RELATED CLAIM #________________ DATE OF INJURY / /

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE. I UNDERSTAND THAT ALL SERVICES NOT COVERED BY MY INSURANCE WILL BE MY RESPONSIBILITY.

PATIENT/GUARANTOR SIGNATURE ______________________________ ***DATE*** ______________

(PARENT IF PATIENT IS A MINOR)