Today's Date:_____

Please indicate whether you would like to have a nurse present during your exam.

Check one and initial.

[ ] Requested
[ ] Denied

X _____

Personal Information

Name: _____
Date of Birth: _____ Social Security Number: _____
Physical Address: _____
Mailing Address: _____
City & State: _____ Zip Code: _____
Phone #: Home: _____ Work: _____
Cell: _____ Other: _____

Email address: _____

Occupation: _____ Employer: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other
Referred by: _____

Your Preferred Pharmacy: _____

Spouses, Guarantor or Significant Other Information

Name: _____
Date of Birth: _____ Social Security Number: _____
Occupation: _____ Employer: _____
Phone #: Home: _____ Work: _____ Cell: _____

May we disclose health/billing information to this person? ☐ Yes ☐ No

Other than my spouse, guarantor or significant other, I give permission for the following individual(s) to be able to discuss my chart/billing with either the doctor, nurse or office staff.

_____

_____

Emergency Contact Information: (Parent, nearest relative or friend someone not living with you)

Name: _____ Relationship: _____
Address: _____
City & State: _____ Zip Code: _____
Phone#: Home: _____ Cell: _____

Insurance Information

Primary: _____ Secondary: _____
ID#: _____ ID#: _____
Group#: _____ Group#: _____
Subscriber: _____ Subscriber: _____

Authorization to release medical information to insurance company or another physician care for patient. I realize, I am responsible for all charges regardless of insurance. I herby authorize my insurance benefits to be paid directly to the undersigned physician.

Patient's Signature: _____