Doctor: _____ ***Patient ID #:***

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** [ ]M [ ]F

Address: _____ **Social Security #:** _____

_____ **Phone:** _____ [ ]Home [ ]Work [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Other

City,State, Zip: _____ **Phone:** _____ [ ]Home [ ]Work [ ]Other

Pharmacy Name & Address: _____ **Marital Status:** [ ]Married [ ]Single [ ]Divorced

_____ **Email Address:** _____

Ethnicity: [ ]Hispanic or Latino [ ]Not Hispanic or Latino [ ]Declined **Preferred Language:** _____

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Patient Declined

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Referring Physician: _____

Primary Physician: _____

Employer's Name: _____

EMERGENCY CONTACTS

Employer's Phone: _____

Name	*Relationship*	*Phone*

Occupation: _____

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: _____ **Employer:** _____

Address: _____ **Home Phone:** _____

_____ **Work Phone:** _____

SSN: _____

City,State, Zip: _____ **Date of Birth:** _____

PRIMARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: _____ **Address:** _____

City, State, & Zip: _____ **Phone:** _____

Claim Number: _____ **Date of Injury:** _____ **Employer @ time of Injury:** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE