



*****PLEASE READ*****

- Information areas marked with an * are required.
- Photo ID and insurance cards are required at appointment time.
- Copay or Co-insurance payment is expected at appointment time. (Doctor's office only)

PATIENT INFORMATION

*Patient Name: _____
 *Complete Address: _____
 *Date of birth: _____ Marital Status: S M D W
 *Social Security #: _____
 *Home Phone: _____ Cell Phone: _____
 *Employer: _____ *Work phone: _____
 Email address: _____ Would you like access to the patient portal? Y or N
 Primary Care Provider: _____

Emergency Contact (outside the home): _____
 Relationship to patient: _____
 Emergency contact phone #: _____

How did you hear about us?
 Medical provider Friend/family
 Online Other

Pharmacy Name: _____
 Pharmacy Location (cross streets): _____

****If patient is a minor, please complete guarantor information below:**

*Guarantor Name: _____
 *Guarantor Address (if different from above): _____
 *Guarantor date of birth: _____ *Guarantor Social Security #: _____

INSURANCE INFORMATION

*Primary Insurance Subscriber #: _____
 *Subscriber Name: _____ Subscriber Date of Birth: _____
 *Secondary Insurance Subscriber #: _____
 *Subscriber Name: _____ Subscriber Date of Birth: _____

By signing below, you are certifying that all information is true and accurate to the best of your knowledge.

Patient/Guarantor Signature: _____ Date: _____
 Relationship to patient: _____