PATIENT INFORMATION *(Please Print)*

Today's Date ____/____/____

Name ____

Date of Birth ______/______/______ Age _____ Sex ____ Marital Status _____________

Mailing Address ____
City State Zip

Home Phone _________________________ Work Phone ____________________ Cell _____________________

Is it ok to leave a detailed message at any of the above numbers? Yes_____ No_____ (Home, Work, Cell)

Email ____

Preferred Method of contact: Phone (Home, Work, Cell) Email Mail Patient Portal

PARENT, or EMERGENCY CONTACT

Name ____
Last First M.I.

Address____
City State Zip

Home Phone _____________________ Work Phone_____________________
Area Code Area Code

INSURANCE INFORMATION (Please present insurance card and Driver's License at time of check in.)

Policy Holder ________________________________ Male _____ Female ________

Policy Holder's Date of Birth ______/______/______

Policy Holders Address: ____

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Relationship of patient to the Insured __________________________

Pharmacy of choice ____ Phone ___________________

Name of Referring Physician: ____Phone___________________

Mailing Address ____
City State Zip

Primary Care Physician ____Phone____________________

Mailing Address ____
City State Zip

Ethnicity: (circle which apply) Hispanic/Latino Not Hispanic/Latino Decline to answer

Race: (circle which apply) American Indian/Alaskan Native Asian White Black/African American
Decline to answer

Preferred Language: ______________________________

Place of Birth: _________________________________