Last Name First MI

Address City State Zip

Home Phone ( ) Cell Phone ( ) Work phone ( ) Date of Birth Sex Marital Status SSN - -

Employment Status Student Status

Employer Address

Emergency Contact Relationship

Address Phone ( )

**IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT COMPLETE THIS SECTION**

Name of responsible party Relationship

Address Phone ( )

Employed by Phone ( )

Employer’s Address

**MEDICAL INSURANCE INFORMATION**

Primary Insurance Name & Address

Policy number Group number Office visit co-pay

Policyholder Policyholder Date of Birth

Secondary Insurance Name & Address

Policy number Group number

Policyholder Policyholder Date of Birth

E-mail address:

Race (please circle): Asian Native Hawaiian or other Pacific Islander Black or African American White Other

Ethnicity (please circle): Hispanic or Latin Not Hispanic or Latin Primary Language:

**Local Pharmacy** (Name & Address)

**Mail Order Pharmacy** (Name & Address)

**AUTHORIZATION**

The above information is true and correct to the best of my knowledge

Signature of Patient (or Parent of Minor Patient) Date