## PATIENT INFORMATION

Today's Date: ____________________ Account Number: ____________________

Patient Name: ________________________________________________________________
*First* *Middle* *Last*

Address: ________________________________________________________________
*Street* *City* *State* *Zip*

Date of Birth: ____________________ Age: __________ Social Security Number: _____________ ☐ MALE ☐ FEMALE

Preferred Phone: (_____) ____________ ☐ Home ☐ Cell Secondary Phone: (_____) ____________ ☐ Home ☐ Cell

Email: ____________________________________________ Driver's License Number: ___________________________

☐ Check here if you ***DO NOT*** consent to receiving email/text messages, including appointment reminder messages

*I authorize the practice to disclose or provide Protected Health Information to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication. This authorization is in effect until a written notification of revocation is received:*

☐ Preferred Phone ☐ Secondary Phone ☐ Email listed above ☐ Mailing Address listed above

Primary Care Physician Name: _____________________________ Address: ____________________________________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black
☐ White ☐ Native Hawaiian/Other Pacific Islander

## EMERGENCY CONTACT

Name: ______________________ Relation: _______________ Phone: _____________

## PREFERRED PHARMACY

Pharmacy: __________________________ Address: _____________________________

## RESPONSIBLE PARTY*

**Only complete this section if the patient is NOT the responsible party*

Name: ______________________ Relation: _______________ Phone: _____________

Address: ________________________________________________________________
*Street* *City* *State* *Zip*

## HOW DID YOU FIND US?

☐ Doctor: ____________________________________________ ☐ Insurance Referral

☐ Internet/Online ☐ Friend/Family ☐ Social Media ☐ Advertisement/Other

## MEDICAL INSURANCE

**PRIMARY Insurance Co.**: _____________________ Member ID: ___________________ Group/Policy No.: _____________

Policy Holder Name/DOB: ______________________________________________ Relation to Patient: ________________

**PRIMARY Insurance Co.**: _____________________ Member ID: ___________________ Group/Policy No.: _____________

Policy Holder Name/DOB: ______________________________________________ Relation to Patient: ________________

*My signature below indicates the above information is correct and accurate to the best of my knowledge.*

**Name:** _________________________________ **Signature:** ______________________________ **Date:** _______________