



**PATIENT INFORMATION**

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:** \_\_\_\_\_  
\_\_\_\_\_

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:** \_\_\_\_\_

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_