

**Patient Information**

Printed Date		Reason for Visit		Date of Injury / Illness	
Patient Number	Social Security No.	Last Name	First Name	MI	Birth Date
Address			City	State	Zip Code
Home Phone		Work Phone		Cell Phone	Gender
Appointment Reminder Contact Preference: <i>I authorize the following to be called for appointment reminders</i> <b>Home Phone</b> <input type="checkbox"/> <b>Work Phone</b> <input type="checkbox"/> <b>Cell Phone</b> <input type="checkbox"/> <b>Do Not Contact</b> <input type="checkbox"/>					
Employer Name		Employer Address, Phone		Patient Email Address: <i>I Authorize use for receipt of patient statements and patient satisfaction surveys.</i> <input type="checkbox"/>	
				_____@_____	
Marital Status (Circle One) <b>Single / Married / Divorced</b> <b>Widowed / Separated</b>		Employment Status (Circle One) <b>Full Time / Part Time</b> <b>Not Employed / Self Employed</b> <b>Retired / Military Duty</b>		Student Status (Circle One) <b>Full Time / Part Time</b> <b>Not a Student</b>	

**GUARANTOR INFORMATION: COMPLETE ONLY IF DIFFERENT FROM PATIENT**

Last Name		First Name		MI	Patient Relationship to Guarantor
Address			City	State	Zip Code
Home Phone		Work Phone		Cell Phone	
Gender	Birth Date	Social Security No.		Employer Name	
Employer Address		Employer Phone		Guarantor Email Address: <i>I Authorize use for receipt of patient statements and patient satisfaction surveys.</i> <input type="checkbox"/>	
				_____@_____	

**EMERGENCY CONTACT**

Emergency Contact	Home Phone	Work Phone	Emergency Contact Relationship to Patient

**PRIMARY INSURANCE**

*Fill in if no copy of card*

**SECONDARY INSURANCE**

Insurance Name		Claims Address		Insurance Name		Claims Address	
City, State, Zip		Ins Ph. No.		City, State, Zip		Ins Ph. No.	
Effective Date	Exp Date	Subscriber Birth Date		Effective Date	Exp Date	Subscriber Birth Date	
Subscriber Name		Policy No.		Subscriber Name		Policy No.	
Subscriber Address		City, State	Zip	Subscriber Address		City, State	Zip
Subscriber SSN	Subscriber Employer			Subscriber SSN	Subscriber Employer		
Group Name		Group No.		Group Name		Group No.	
Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			

**GENERAL INFORMATION**

Race (Circle all that apply) Entered: American Indian/Alaskan Native Asian Black/African American Native Hawaiian Other Pacific Islander White Decline to Report	Ethnicity (Circle One) Entered: Hispanic/Latino Non-hispanic/Non-Latino Decline to Report	Primary Language (Circle One) Entered: English Spanish Chinese Russian Other: _____
	Do you need an interpreter? Yes / No	
How did you hear about us?		
Have you been seen here before? Yes / No	Primary Care Physician	
Is this visit due to a work-related illness/injury? Yes / No	If yes, please list the employer's name	
What is your pharmacy's name and location?		

**Authorization To Pay Benefits To Provider:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider when he accepts assignment.

**Authorization To Release Medical Information.** I hereby authorize my Provider to release any information necessary for my course of treatment.

I have reviewed the information above and made any necessary changes. \_\_\_\_\_ (patient/guardian initial)

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date