## PATIENT'S INFORMATION

Date: ______________________ Social Security#: ______________________

Patient Name: ____________________________________________
Last Name Suffix First Name MI

Permanent Mailing Address: ____________________________________________
Street City/State Zip Code

Physical Address: ____________________________________________
(If different than mailing) Street City/State Zip Code

Home Phone: ______________________ Cell Phone: ______________________

Sex: ☐ M ☐ F DOB: ______________

Gender Identity: ☐ Female-to Male/ Transgender Male ☐ Male-to-Female/ Transgender Female ☐ Non-Binary/ Genderqueer ☐ Others

Employer Name: ______________________ Employer Phone: ______________

Employer Address: ____________________________________________
Street/Mailing City/State Zip Code

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed ☐ Self-Employed ☐ Active Military Duty

E-mail Address: ____________________________________________

Primary Care Physician: ____________________________________________

PCP City: ______________________ PCP Phone: ______________________

Marital Status: ____________________________________________

Race: ______________________ Ethnicity: ☐ Hispanic ☐ Not Hispanic

## REFERRAL INFORMATION

**How were you referred to us?**

☐ Physician ☐ ER / Urgent Care ☐ Family Member/Friend ☐ Employer ☐ Website ☐ TV ☐ Newspaper ☐ Radio

If physician or medical facility referral, please list the name: ______________________

Physician/Facility City: ______________________ Physician/Facility Phone: ______________________

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## INSURANCE INFORMATION

**Primary Insurance Co.:** ______________________________

Subscriber's Full Name: ______________________________

Subscriber's Address: ______________________________
(If different than patient) Street City/State Zip Code

Subscriber's Sex: ☐ M ☐ F Subscriber's DOB: ____________ Subscriber's SS#: ____________

Subscriber's Relationship to the patient: ______________________________

Subscriber's Employer: ____________________ Employer's Phone: ____________

Subscriber's Employer Address: ______________________________

**Secondary Insurance Co.:** ______________________________

Subscriber's Full Name: ______________________________

Subscriber's Address: ______________________________
(If different than patient) Street City/State Zip Code

Subscriber's Sex: ☐ M ☐ F Subscriber's DOB: ____________ Subscriber's SS#: ____________

Subscriber's Relationship to the Patient: ______________________________

Subscriber's Employer: ____________________ Employer's Phone: ____________

Subscriber's Employer Address: ______________________________

## PARENT INFORMATION

(If minor child)

**Father's Name**: ______________________________
Last Name Suffix First Name MI

Father's Home Phone: ____________ Father's Cell Phone: ____________

Father's Mailing Address: ______________________________
(If not listed as subscriber) Street City/State Zip Code

Father's DOB: ____________ Father's SS#: ____________

Father's E-mail: ______________________________

Father's Employer: ______________________________
(If not listed as subscriber)
Employer's Address: ______________________________

**Mother's Name:** ______________________________
Last Name First Name MI

Mother's Home Phone: ____________ Mother's Cell Phone: ____________

Mother's Mailing Address: ______________________________
(If not listed as subscriber) Street City/State Zip Code

Mother's DOB: ____________ Mother's SS#: ____________

Mother's E-mail: ______________________________

Mother's Employer: ______________________________
(If not listed as subscriber)
Employer's Address: ______________________________