PATIENT'S INFORMATION **Date: ________________**

Patient Name: ____
Last Name *Suffix* *First Name* *MI*

Permanent Mailing Address: ____

Physical Address: ____
If different than mailing

Home Phone: ____________________ Cell Phone: ____________________ DOB: ____________________

Social Security #: ____________________ E-Mail: ____________________________ Marital Status _____

Race: ________________ Ethnicity: ☐ Hispanic ☐ Not Hispanic Language ________________________

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

Employer Name: ______________________________________ Employer Phone: ____________________

Employer Address: ____

Preferred Pharmacy: __________________ Pharmacy Location ____________________________________

Emergency Contact: _____________________ Relationship: _____________ Phone: ____________________
Leave blank if none

INSURANCE INFORMATION

Is this visit due to one of the following? ☐ Worker's Comp ☐ Liability ☐ Motor Vehicle Date of Injury: ____________

Primary Insurance Co.: _________________________________ Relationship to Subscriber: _____________
If patient is not the subscriber complete the following.

Subscriber's Full Name: ____ SSN: __________________

Subscriber's Address: ____

Subscriber's Sex: ☐ M ☐ F DOB: ____________________ Employer: _______________________________

Subscriber's Employer Address & Phone: ____

Secondary Insurance Co.: _______________________________ Relationship to Subscriber: _____________
If patient is not the subscriber complete the following.

Subscriber's Full Name: ____ SSN: __________________

Subscriber's Address: ____

Subscriber's Sex: ☐ M ☐ F DOB: ____________________ Employer: _______________________________

Subscriber's Employer Address & Phone: ____

PARENT/GUARDIAN INFORMATION

If patient is a minor.

Father's Name: ____

Last Name *Suffix* *First Name* *MI*

Father's Mailing Address: ____

Father's Home Phone: ________________________ Cell Phone: ________________________

Father's DOB: ______________ Father's SS#: ______________________

Father's Employer: ____

Employer Address: ________________________________ Phone: ____________________

Mother's Name: ____

Last Name *Suffix* *First Name* *MI*

Mother's Mailing Address: ____

Mother's Home Phone: ________________________ Cell Phone: ________________________

Mother's DOB: ______________ Mother's SS#: ______________________

Mother's Employer: ____

Employer Address: ________________________________ Phone: ____________________