



# Patient Information Form

## Personal Information

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status:  Married  Divorced  Single  Domestic Partner

Home Address: \_\_\_\_\_

Address (Line 2): \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

If provider referral, list provider: \_\_\_\_\_

Primary Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Insured Person/Spouse Information

Relationship: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**If Patient Is a Minor, Person Responsible for Bill**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Address (Line 2): \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**Nearest Relative to Notify in case of an Emergency** Relationship: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Address (Line 2): \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**Please list the name & relationship of the person(s) to which we may release your medical records to**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Benefits to Provider Authorization**

Signed (Patient or Parent/Guardian if Minor):

\_\_\_\_\_ Date: \_\_\_\_\_