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 authorize the following to be called for appointment reminders*
Home Phone ☐ **Work Phone** ☐ **Cell Phone** ☐ **Do Not Contact** ☐

Employer Name	Employer Address, Phone	Patient Email Address: *I Authorize use for receipt of patient statements and patient satisfaction surveys.* ☐

Marital Status (Circle One) Entered: **Single** **Single / Married / Divorced** **Widowed / Separated**	Employment Status (Circle One) **Full Time / Part Time** **Not Employed / Self Employed** **Retired / Military Duty**	Student Status (Circle One) **Full Time / Part Time** **Not a Student**

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 Authorize use for receipt of patient statements and patient satisfaction surveys.* ☐ **D**

EMERGENCY CONTACT

Emergency Contact Name	Emergency Contact DOB	Home Phone Work Phone	Cell Phone	Emergency Contact Relationship to Patient (Circle One) **Father /Mother / Guardian** **Sibling / Child / Other**
_____	_____			

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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 ☐ Spouse ☐ Child ☐ Other ☐		Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

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? Entered: **Yes / No**	
How did you hear about us?	Advance Directive Status	Date Verified
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**