



**PATIENT INFORMATION**

Date \_\_\_/\_\_\_/\_\_\_ Primary Care Physician \_\_\_\_\_ Pharmacy\_\_\_\_\_

**Patient**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ Marital Status (please circle) S M D W SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ Gender M / F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Notify in case of an emergency**

Relationship \_\_\_\_\_

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

Home phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Primary Policy Holder's Information and/or Responsible Party**

Policy Holder (Name) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder DOB \_\_\_/\_\_\_/\_\_\_ Policy Holder SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ Employee Status FT/PT/Retired

Insurance Company \_\_\_\_\_ Co-pay \$ \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Additional Insurance Information (Secondary Insurance)**

Policy Holder (Name) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder DOB \_\_\_/\_\_\_/\_\_\_ Policy Holder's SSN \_\_\_/\_\_\_/\_\_\_ Employee Status FT/PT/Retired

Insurance Company \_\_\_\_\_ Co-pay \$ \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

I authorize the release of any information concerning my (or my child's) healthcare and treatment for the purposes of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. (We will file a claim with your insurance company for services provided. In the event of non-payment, you will be responsible for the charges incurred today.)

X \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

(Signature of patient or parent/guardian of minor)