Patient Demographics

Last Name_______________________ First Name_______________________ MI _______
DOB____/____/____ SSN_______________________ Marital Status S__ M__ D__ W__ M/F
Cell #_______________________ Home #_______________________ Race ____________
Email____
Address____
City________________________________ State_________________ Zip _____________
Employer_____________________________________ Employer Phone________________
Address____
Family Physician_______________________________ Phone_________________________
Preferred Pharmacy_____________________________ Phone_________________________

Parent/Spouse/Guardian-Circle One if Applicable

Last Name_______________________ First Name_______________________ MI_______
Home #______________________________ Cell #_______________________________
DOB____/____/____ SSN___________________ M/F Email_________________________
Address____
City______________________________ State_____________________ Zip____________

Emergency Contact

Name_______________________________________ Phone___________________________

Insurance

Policy Holder Name________________________ DOB___/___/___ SSN________________
Primary_________________________________ Secondary___________________________
Policy#_________________________________ Policy#______________________________
Group#__________________________________ Group#_______________________________

I authorize the release of any information necessary to process the insurance claim. I understand that I am financially responsible for this account regardless of insurance coverage and for payment of any amount not covered by my insurance company. I agree to pay collections costs and reasonable attorney fees incurred in attempting to collect on a defaulted account.

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Signature **Date**