## PATIENT INFORMATION

Patient's Name (Last, First, Middle)_____

In order to comply with new health care reform initiatives, we are required to ask your ethnicity and language.

***A**merican Indian or **A**laska Native* ***A**sian* ***B**lack or **A**frican American*

***H**ispanic/Latino* ***N**ative Hawaiian* ***W**hite* ***D**eclined*

What is your preferred language? _____Gender: M / F

Birth date _____Social Security_____

Address_____

City_____ State_____ZIP_____

Cell _____ Home Phone_____ Work Phone_____

Responsible party Name_____ Birthday _____

Phone_____ May we leave a message at your home number or text you? □ Yes □ No

Patient portal access and reminders - email address _____

## INSURANCE INFORMATION

Insurance Name / Policy Holder's Name_____ / _____

Policy Holder's Birth date_____ Social Security _____

Policy Holder's relationship to the patient _____

Insurance ID Number _____Group Number _____

## WHICH PHARMACY DO YOU PREFER?

1st Pharmacy Name _____ Est. Address _____

2nd Pharmacy Name _____ Est. Address_____

Mail Order Pharmacy _____ Phone_____

## EMERGENCY CONTACT INFORMATION

Please give the names of two nearest relatives not living with you:

Name _____

Relationship _____ Phone _____

Name _____

Relationship _____ Phone _____

I certify that the information I have given on this sheet is true and correct. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for all services rendered in this office. If I have insurance coverage, it is my responsibility to make sure that the insurance company pays. Also, I understand that should collection action become necessary, the responsible party agrees to pay additional 35% collections fees, and all legal fees, including attorney's fees and court costs.
By signing this form you are giving us consent to access your external prescription history.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____

PLEASE PRINT PATIENT NAME