



PLEASE PRINT

Today's Date: _____

GENERAL INFORMATION

Name: _____

Last First M.I.

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Marital Status: _____ Name of Spouse/Partner: _____

Employer: _____ Email: _____

Home Address: _____

Home Phone: _____ Cell: _____ Work: _____

Referred By: _____ Relationship: _____

Primary Care Doctor: _____ Address: _____

Pharmacy Number: _____

EMERGENCY CONTACT INFORMATION

Contact Person: _____ Phone: _____

INSURANCE INFORMATION (FOR PARTICIPATING PLANS ONLY)

Primary Insurance: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Policy Number: _____ Group #: _____

Claims Address: _____

Relationship to Insured: Self Spouse Partner Child Other: _____

COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI)

At which number should we attempt to contact you first? _____

At which number may we leave a message for you? _____

May we leave an appointment reminder? _____

May we mail you information on our specials/events? _____

May we email personal medical information to you? _____

Signature: _____

Date: _____