Patient Information			
Name (Last, First, Middle Initial)	Date of Birth	Social Security #	
Local Address	Home Phone	Sex	Marital Status
City, State, Zip	Secondary Billing Address (If Applicable)		
Work Phone	City, State, Zip		
Cell Phone	Primary Employer		
Referring Physician	Employer's Address		
E-Mail Address	City, State, Zip		

Responsible Party/Emergency Contact Information (if different than above)			
Name (Last, First, Middle Initial)	Social Security #	Date of Birth	Sex
Local Address	Name of Nearest Friend/Relative That Does Not Live with Patient		
City, State, Zip	Local Address		
Home Phone	City, State, Zip		
Relationship to Patient	Home Phone		

Primary Insurance		
Name of Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group #	
Address of Insurance Company	Co-pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

Secondary Insurance		
Name of Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group #	
Address of Insurance Company	Co-pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

Signature of Patient/Guardian____ Date__________

Patient's Name____DOB___________________

Is today's visit related to a Work Related Injury? ______Yes ______No
If you answered yes, please notify the receptionist immediately.

Please tell us the pharmacy you want us to send your prescriptions to. Please list only one pharmacy.

Pharmacy Name ____

Pharmacy Address ____

____

____

Pharmacy Phone Number ____

Signature of Patient/Guardian____ Date__________