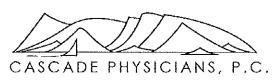
Version: DEMO/MSG (3/11/2016)



PATIENT INFO					
Last Name:		First Name:		Middle Initial:	
Preferred Name:			Date of Birth:	Sex:	
Address:			Social Security #:		
City:	State:	Zip:	Marital Status: □Single □Marri	ed □Partner □Widowed □Divorced	
Primary phone: □Mobile □Ok to leave detailed message?				Race:	
Secondary phone:   Mobile   Ok to leave detailed message?			Ethnicity:		
Work Phone:		Ext:	Employer Name ar	nd Address:	
Email:					
Do you have an Advanced Directive or POLST? ☐Yes ☐ No			' '	Employment Status:  □Full Time □Part Time □Retired □Not employed	
EMERGENCY CONTACT				■ Patient Here	
Last Name: First Name: MI:		□Spouse □Pal □Other:			
$\hfill \square$ Okay to leave a detailed message with this	contact Phone	1:	Phone 2:		
Address (if different from patient):			Date of Birth:		
ADDITIONAL EMERGENCY	CONTACT			■ Patient Here	
Last Name: First Name:		MI:			
			☐ ☐Friend ☐Chile	d □Parent □Other:	
☐ Okay to leave a detailed message with this contact Phone 1:		1:	Phone 2:	Phone 2:	
Address (if different from patient):			Date of Birth:		
PRIMARY INSURANCE					
Insurance Company Name:	ID Number:			Group Number:	
Claims Address:	1		Claims Phone Num	ber:	
Primary Subscriber Name (if different from pal	lient): Date of Birth:			Relationship to patient:  □Spouse □Partner □Parent □Other:  Social Security #:	
Phone 1:	Phone 2:				
If you have more than one insurance plan, please ma	ke sure to provide tha	t information to the office at the time o	of service.		
PREFERRED PHARMACY					
Pharmacy Name:		Pharmacy Phone Number:		Pharmacy Fax Number:	
Pharmacy Address:	··		City, State, Zip:		
ayment is due at time of service. If patient is covered to ecessary, please discuss other financial arrangements acknowledge that I am financially responsible for all ch	with our billing office.	<ul> <li>Finance charges will be assessed aft</li> </ul>	ter 90 days. Visa and MasterCi	ard are available for your convenience.	
osts and expenses, including reasonable attorney fees SIGNATURE:	. I hereby authorize th	e doctor to release information neces	sary to secure the payment of	benefits.	
Patient Signature (or Guardian):			Date:	Date:	
Whom may we thank for referring you?			Relationship:	Relationship:	