PATIENT INFORMATION

DATE:_____

PATIENTS NAME:_____ ☐MALE ☐FEMALE - DATE OF BIRTH:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

RACE(CHECK ONE): ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN/ PACIFIC ISLANDER ☐ OTHER ☐ WHITE

ETHNICITY: ☐NOT HISPANIC/LATINO ☐HISPANIC/LATINO

PREFERRED LANGUAGE:☐ ENGLISH ☐ PORTUGUESE ☐ SPANISH ☐ OTHER_____

PARENT/GUARDIAN:_____DATE OF BIRTH_____SSN:_____

PHONE(H):_____WORK_____CELL_____**EMERGENCY**_____

PARENT/GUARDIAN:_____DATE OF BIRTH_____SSN:_____

PHONE(**H):**_____WORK_____CELL_____**EMERGENCY**_____

**** YOU MUST HAVE AT LEAST TWO PHONE NUMBER'S ALONG WITH AN EMERGENCY PHONE NUMBER.****

ADDRESS(If different from above):_____CITY_____STATE_____ZIP_____

OK TO LEAVE A MESS: ☐NO ☐BRIEF ☐ EXTENDED ☐AT HOME ☐CELL

PHARMACY NAME:_____ADDRESS:_____CITY_____

E-MAIL:_____

(We are in the process of gathering EMAIL addresses to better communicate with our patients in the future.)

INSURANCE AND BILLING INFORMATION

PERSON RESPONSIBLE: ☐ FATHER ☐ MOTHER ☐ OTHER

BILLING ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE:_____

PRIMARY INSURANCE:_____EFFECTIVE DATE_____COPAY_____

SUBSCRIBERS NAME:_____ DOB:_____

ID#:_____GROUP ID:_____

SECONDARY INSURANCE:_____EFFECTIVE DATE_____COPAY_____

SUBSCRIBERS NAME:_____ DOB:_____

ID#:_____GROUP ID:_____

I, the undersigned, verify that the information listed above is true and accurate to the best of my knowledge. Any changes to the information listed have been made and initialed.

RELEASE OF INFORMATION AUTHORIZATION: I, the undersigned, authorize the release of any information required in the course of my treatment to my insurance carrier or other health provider I am consulting.

ASSIGNMENT OF BENEFITS AUTHORIZATION: I, the undersigned, assign to the provider(s) or supplier all insurance payments for the medical services rendered. I also acknowledge personal responsibility for payment of all medical fees in the event they are not paid by my insurance plan.

Please check if you have received a copy of our PRIVACY POLICY: ☐

SIGNATURE:_____DATE:_____