

Patient's Name:		Patient's Birthdate:	Patient's Sex:
Patient's Former/Previous Name/Nickname:			
Home Phone #:	Cell Phone #:	Social Security Number:	Marital Status:
Mailing Address:			
Preferred Language:	Ethnicity & Race (Check one): <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/> Native American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black		
Employment Status: <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Full-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired: Date _____ <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student Full-Time <input type="checkbox"/> Student Part-Time <input type="checkbox"/> Disabled: Date _____			
Employer Name, Address, and Phone Number:			
Preferred Pharmacy:		Mail Order Pharmacy:	
Primary Care Provider:			

Parent/Guardian Information if Under 18 years of age/Person consenting to treatment

Parent/Guardian Name:	
Relationship to Patient:	Parent/Guardian Date of Birth:
Address and Phone Number(if different from Patient):	

Insurance Information –Please provide insurance card(s) to the receptionist

Primary Insurance:	Policy Holder's Name:
Policy Holder's Date of Birth:	Relationship to Patient:
Policy ID Number:	Policy Holder's Employer:
Policy Holder's Address (if Different from Patient):	
Secondary Insurance:	Policy Holder's Name:
Policy Holder's Date of Birth:	Relationship to Patient:
Policy ID Number:	Policy Holder's Employer:
Policy Holder's Address (if Different from Patient):	
Tertiary Insurance:	Policy Holder's Name:
Policy Holder's Date of Birth:	Relationship to Patient:
Policy ID Number:	Policy Holder's Employer:
Policy Holder's Address (if Different from Patient):	