PATIENT INFORMATION			
LAST NAME:	FIRST NAME: M.I.:		DATE OF BIRTH:
MAILING ADDRESS:	CITY/STATE/ZIP:		
HOME PHONE:	CELL PHONE:	WORK PHONE:	
SSN:	SEX (CIRCLE ONE): MALE / FEMALE	MARITAL STATUS (CIRCLE ONE): SINGLE/MARRIED/DIVORCED/WIDOWED	
EMPLOYER:	OCCUPATION:		
PRIMARY CARE PROVIDER:	PREFERRED PHARMACY AND LOCATION:		
PATIENT EMAIL ADDRESS (PARENT/GUARDIAN EMAIL IF PATIENT IS A MINOR):			

RESPONSIBLE PARTY (If the patient is a minor please fill the below section out in its entirety.)			
LAST NAME:	FIRST NAME: M.I.:		DATE OF BIRTH:
MAILING ADDRESS (IF DIFFERENT THAN PATIENT):	CITY/STATE/ZIP:		
PHONE:	SSN:	RELATIONSHIP TO PATIENT:	
LAST NAME:	FIRST NAME: M.I.:		DATE OF BIRTH:
MAILING ADDRESS (IF DIFFERENT THAN PATIENT):	CITY/STATE/ZIP:		
PHONE:	SSN:	RELATIONSHIP TO PATIENT:	

ADDITONAL INFORMATION		
EMERGENCY CONTACT:	PHONE:	RELATIONSHIP TO PATIENT:

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY:	COMPANY:
POLICY HOLDER NAME:	POLICY HOLDER NAME:
POLICY HOLDER DOB:	POLICY HOLDER DOB:
PATIENT RELATIONSHIP TO POLICY HOLDER:	PATIENT RELATIONSHIP TO POLICY HOLDER:

THIRD PARTY LIABILITY **We do not bill 3rd party liability insurance. IE: You're in an auto accident and the other driver is at fault we do not bill their auto insurance. **	
WORK RELATED INJURY (CIRCLE ONE): YES / NO	MOTOR VEHICLE ACCIDENT (CIRCLE ONE): YES / NO
DATE OF INJURY:	DATE OF ACCIDENT:
EMPLOYER AT TIME:	STATE ACCIDENT OCCURRED:
WORK COMP INS COMPANY:	VEHICLE INS COMPANY:
CLAIM #:	CLAIM #:

Patient/Legal Guardian Signature: _____ Date: _____