PATIENT'S PERSONAL INFORMATION TODAY'S DATE: ___________________

Patient's (LEGAL) Name:_____________________________________ Known as:___________________
(Nickname)

If under 18 provide Parent Information.
Parent 1 Name______________________DOB_________ Parent 2 Name______________DOB_______________

Address:____________________________________ City:______________ State:_____ Zip:__________

Date of Birth: ___________________ Gender: Male Female Trans Identified Non-Conforming

Race _________________________ Preferred Language (s)_____________________________________

Social Security#_________________ How Did You Hear About Our Practice? ______________________

Phone: Home________________ Work_________________ Cell _________________________________

Preferred Phone Circle One: Home Work Cell Ok To Leave Messages? Yes No

E-Mail Address _____________________________ Spouse/Partner or Parents Name_______________

Emergency Contact: __________________ Phone No._______________ Relationship: Spouse, Partner, Parent, Friend

Pharmacy Name & Location: ______________________ UNC Hospital No.__________ Duke MRN#______

INSURANCE INFORMATION

Primary Insurance: _________________________ Policyholder Name & Date of Birth___________________

Secondary Insurance: _______________________ Policyholder Name & Date of Birth___________________

If you would like your medical information released to your Spouse, Partner, Parent, please write in their name ___________________________ and sign your name below.

Sign:______________________________________ Date:__________________

*********NOTICE*********

PLEASE GIVE US 24 HOUR NOTICE IF YOU NEED TO CANCEL, CHANAGE OR ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT; OTHERWISE IT IS CONSIDERED A MISSED APPOINTMENT & THERE WILL BE A $60.00 CHARGE. IF YOU ARE 15 MINUTES LATE TO YOUR APPOINTMENT YOU MAY BE ASKED TO RESCHEDULE AND MAY BE CHARGED THE $60.00 MISSED APPOINTMENT FEE.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT________________________
Signature