

PATIENT'S PERSONAL INFORMATION

TODAY'S DATE: _____

Patient's (LEGAL) Name: _____ Known as: _____
(Nickname)

If under 18 please provide Parent Information Mother's Name _____ DOB _____ Father _____ DOB _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: Male Female Trans-Identified Non-Binary Other

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: _____

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, CHANGE 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**