Patient Information Sheet

PLEASE PRINT

Your Name: ____ **Doctor of Record:** ___________________________

Social Security Number: ____________________

Home Address: ____City: _________________State: _________ Zip: _________

Primary Phone: _________________________________ Secondary Phone: _________________________________

Gender ___Male ___Female

Email Address: ____(required for secure messaging/patient portal)

Text/Carrier: ____

Guarantor Name: ____ Date of Birth: ____________________________

Address: ____ City: __________________ State: __________ Zip:_______

Primary Insurance Company: ____

Contract Number: ______________________________ Group Number: _______________________ Co-Pay $ __________

Insurance Address: ____

Policy Holder Name: ____________________________________ Policy Holder Date of Birth: _______________________

How are you related to the policy holder: Self Spouse Child Other: ______________________

Secondary Insurance Company: ____

Contract Number: ______________________________ Group Number: _______________________ Co-Pay $ __________

Insurance Address: ____

Policy Holder Name: ____________________________________ Policy Holder Date of Birth: _______________________

How are you related to the policy holder: Self Spouse Child Other: ______________________

Marital Status: ___Single ___Married ___Divorced ___Widowed Language: _______________________

Employment Status: ___Student __Employed Full-Time __Employed Part-time __ Retired __Unemployed __Disabled

Race:_____________ Ethnicity __________

Pharmacy Name: _____________________________ Location:________________________ Telephone:_______________

In case of an emergency, who should we contact:

Name: ____ Relationship: ___________________________

Primary Telephone: _____________________________ Secondary Telephone: _________________________________

Address: ______________________________________ City: __________________ State: ____________ Zip: ___________

I, the undersigned, authorize payment of medical benefits for any services furnished to me by the practitioner. I understand that I am financially responsible for any amount not covered by my insurance. I understand that I am required to pay all co-pays, deductibles or non-covered services at the time of service.

Date: _____/_____/____ Signed ____

____ _______________________________________

Print Name of Parent or Guardian Signature of Parent or Guardian