Patient Name: ____ Date of Birth: ______ / ______ / ______

Street Address: ____ [ ] Male [ ] Female

City, State, Zip: ____ Age: __________

Home Phone: ___________________________ Cell Phone: ______________________________

Work Phone: ___________________________ Email: __________________________________

How would you like to receive reminders of your appointments? [ ] Phone [ ] Text [ ] Email

Preferred Language: _______________________________ How did you hear about us? _____________________

EMPLOYMENT INFORMATION

Employer: ___________________________________ Occupation: ______________________________________

INSURANCE INFORMATION

Insurance Plan: ____ ID: ____________________________________

Subscriber: ______________________________ SSN: _____________________ DOB: ______ / ______ / ______

EMERGENCY CONTACT

Name: _________________________________ Phone : _________________ Relation: _____________________

MEDICAL PROVIDER/PHARMACY INFORMATION

Primary Care Physician: ____ Phone: ____________________

Referring Doctor (if applicable): ____________________________________ Phone: ____________________

Pharmacy Name: __________________________ City: ___________________ Phone: ____________________

PAYMENT OF PROFESSIONAL FEES

*Full payment or co-payments are due at the time of service.

*We are a participating facility and accept Medicare benefits. You are still responsible for the Medicare deductible, 20% co-payment and Refraction fee.

*If your insurance requires referrals, we cannot provide services until YOU have secured one from your Primary Care Physician.

Patient/Authorized Signature: ______________________________________ Date: _____ / ______ / ______

Patient Representative's Name: _____________________________________ Relation to Patient: __________________