PERSONAL INFORMATION

Name____Date________________________

Birthdate____

SS #____

____Male ______Female ____Single ____Married ____Divorced ______Widowed

Address____

City________________________ State_______________________ Zip_________________________

Employer____

Referred By____

CONTACT INFORMATION

Home Phone ______________________________ Pharmacy Phone__________________________

Work Phone_______________________________ Cell Phone ______________________________

Email Address ____

In the event of an emergency, who should we contact?

Name_________________________ Relationship__________________ Phone ___________________

INSURANCE INFORMATION

Primary Insurance

Name of Insured___________________________

Relationship to Patient ______________________

Insured's birth date _________________________

Insured's SS# _____________________________

Insurance Company __________________________

Id Number________________________________

Group Number _____________________________

Claims Address____________________________

Secondary Insurance

Name of Insured ______________________________

Relationship to Patient___________________________

Insured's Birth Date _____________________________

Insured's SS#_________________________________

Insurance Company ____________________________

Id Number_____________________________________

Group Number _________________________________

Claim Address _________________________________

MEDICAL HISTORY

ALLERGIES____

SERIOUS PAST ILLNESSES____

SURGERIES____

PRESENT MEDICATIONS____

Do You Smoke?__________ How much per day?________ How long have you smoked/ _____________

Reason for today's visit____

Who referred you to the doctor?____