Demographic Information

Patient's Name ____

Last First Middle

Male or Female (Please circle one) E-Mail Address ____________________________

Address ____

Street City/State Zip

Home ______________________ Work______________________ Cell_______________

Age __________ Birth Date_________________ Marital Status____________________

Social Security #________________________ Occupation_________________________

Employer____

Name of Spouse/Guardian____

Any Known Drug Allergies____

Any Other Allergies____

Preferred Pharmacy________________________________ Phone #__________________

Pharmacy Address____

Referred By____

Required Information to Process Insurance Claims

Policy Holder's Name____

Policy Holder's Date of Birth__________ Policy Holder's Social Security #__________________

Emergency Contact Information

Name______________________________ Phone____________________________

Address____

Please Allow Us to Copy Your Insurance Card and Photo ID

I understand that I am financially responsible for all charges for my services, including any balance allowed after insurance payment. I authorize payment of medical benefits for myself or the name provided for professional services rendered. I authorize release of medical information necessary to process claims.

Signed____ Date____________________