PATIENT INFORMATION

Patient Name: ______________________ Today's Date: ______________

Address: ______________________ Home Phone: ____________ Cell: ______________

City: ______________ State: _____ Zip Code: _________ Work Phone: ______________

Date of Birth: ____________ Age: _____ Sex: _____ SS#: ______________ Marital Status: M S D W

Highest Level of Education: ❑ Partial HS ❑ HS ❑ Partial College ❑ College ❑ Advanced Degree

Employer Name: ______________ Occupation: ______________ How Long? ________

Employer Address: ______________________________

City: ______________________ State: ______ Zip Code: ____________

Previous Employer (If less than 2 yrs): ______________________________

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Referring Physician's Name & Address: ______________________________

Telephone: ______________ ______________________________

Person to Contact in an Emergency ______________________________

Relationship to patient: ______________________ Telephone: ______________________

Nearest relative or friend not living in household: ______________________________

Relationship to patient: ______________________ Telephone: ______________________

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Primary Insurance Co. ______________________________ ID# ______________

Address ______________________________ Telephone ______________

Insured's Name ______________________ Relationship ____________ Group# ______________

DOB: ____________ Sex: ______ SS# ______________ Employer: ______________

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Secondary Insurance Co. ______________________________ ID# ______________

Address ______________________________ Telephone ______________

Insured's Name ______________________ Relationship ____________ Group# ______________

DOB: ____________ Sex: ______ SS# ______________ Employer: ______________

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Please indicate how we may contact you for appointments. Please note: We will not conduct any other communications about your treatment other than appointments via text messaging, or email.

Preferred method of contact: Phone: ______________ Cell Phone (Text): ______________

Email Address: ______________________________

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To avoid misunderstandings, you should be aware that, generally, you are responsible for all charges regardless of whether your insurance reimburses for services. In certain instances, such as with a preferred provider plan, HMO, or Medicare assignment, the insurance would reimburse me directly. However, you are still responsible for any deductibles and co-payments.

Appointments are made and the time held for you. If you miss your appointment, or you cancel with less than 48 hours notice, and the appointment cannot be filled, a charge will be made which is not reimbursable by insurance.

By signing this form, I authorize release of any medical information necessary to process insurance claims on my behalf. I accept full responsibility for payment of all services rendered as described above. I agree to pay all collection costs and reasonable attorney's fees should I default on my payments and force collection of my debt.

Signature:____ Date: ________________________

PATIENT INFORMATION PHARMACY

Patient Name:_____________________________ Today's Date: ______________

Address: ____

City: ___________________________ State: _____ Zip Code: ___________

Home Phone: ________________ Work Phone_________________

Cell Phone: __________________________

Date of Birth: _______________

Pharmacy Name: _______________________________

Pharmacy Address: _____________________________

Pharmacy Telephone: ____________________________

Do you have a Drug/Medication Insurance Plan? No______ Yes_____, If Yes, please complete the information below:

Drug/Medication Insurance Plan: __________________ID#____________________________

Address____Telephone__________________

Insured's Name __________________Relationship_______________Group#_______________

DOB:_________________