PATIENT INFORMATION SHEET

Patient Name ____ Date _____________
(Last) (First) (Middle Initial)

Street Address ____

City __________________________________ State _________________ Zip Code ________________

Home Phone Number ______________________ Cell Phone Number ____________________________

Date of Birth ____________________ Age _________ Social Security Number ______________________

Marital Status ______________ Occupation ____

Employer _____________________________ Employer Phone Number ___________________________

Employer Address ____

Family Physician _______________________________ Referred By _____________________________

Emergency Contact (friend/relative not living with you) ____

Relationship _________________________ Emergency Contact Phone Number ____________________

Emergency Contact Work Number ________________ Preferred Pharmacy _______________________

Please complete the following section (If a minor, complete parental information)

Name of Spouse/Parent ________________________________ Date of Birth _____________________
(Required for insurance billing)

Occupation ___________________________ Social Security Number ___________________________

Employer ____________________________ Employer Work Phone _____________________________

Employer's Address ____

INSURANCE INFORMATION

Payment is expected at time of service unless previous arrangements have been made.

Primary ________________________________

Policy Holder ____________________________

Holder's Date of Birth _____________________

ID Number ______________________________

Group Number ___________________________

Secondary _______________________________

Policy Holder ____________________________

Holder's Date of Birth _____________________

ID Number ______________________________

Group Number ___________________________

I have read and signed the attached patient consent for use and disclosure of Protected Health Information.

Signature ____