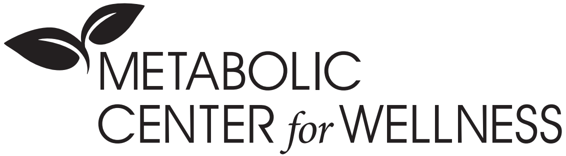

PERSONAL INFORMATION

First Name________________________ Middle ______ Last ____________________________________

DOB ______________ SS#___-__-____ Sex ☐M ☐F Marital Status ____________________________

Street Address____

City ____ State _______ ZIP code ___________

Home Phone #____________________________________ Work Phone # ____________________________

Cell Phone # _____________________________________ E-mail __________________________________

HIPAA COMPLIANCE

Which phone #s may we call to discuss your care? ☐ Home ☐ Cell ☐ Work

On which phone may we leave a voice mail message? ☐ Home ☐ Cell ☐ Work ☐ None

PRIMARY CARE PHYSICIAN

Name____

Phone # ____ Fax # ___________________________________

Address ____

PLEASE LET US KNOW WHO REFERRED YOU (IF APPLICABLE)

Name____

PATIENT'S EMPLOYMENT INFORMATION

Employer ____

Occupation ______________________________________ Phone # _________________________________

Street Address____

City ____ State _______ ZIP code ___________

SPOUSE INFORMATION

Name____ DOB ___________________

Cell phone # _____________________________________ Work phone # ____________________________

May we discuss your medical care with your spouse? ☐ Y ☐ N

Can we discuss your medical care with anyone other than your spouse? ☐ Y ☐ N

Name____

Relationship _____________________________________ Phone # _________________________________

EMERGENCY CONTACT

Name____

Relationship _____________________________________ Phone # _________________________________

HEALTH INSURANCE INFORMATION

Primary Insurance Company____ ID# ________________

Policy Group #____________________________________ Group Name _____________________________

Subscriber's name____ DOB _______________

Secondary Insurance Company ____ ID# ________________

Policy Group #____________________________________ Group Name _____________________________

Subscriber's Name ____ DOB _______________

PHARMACY INFORMATION

Local Pharmacy Name _____________________________ Phone/Fax # ______________________________

Mail Order Pharmacy ______________________________ Phone/Fax # ______________________________

OTHER SPECIALISTS YOU CURRENTLY SEE

Specialist	Name	Phone #
Cardiology		
Neurology		
Nephrology		
OB/GYN		
Opthalmology		
Podiatry		
Psychiatry		

Signature ____ Date _______________
(Patient and/or responsible party)