

Printed Date		Reason for Visit		Date of Injury / Illness	
Patient Number	Social Security No.	Last Name	First Name	MI	Birth Date
Address			City	State	Zip Code
Home Phone		Work Phone		Cell Phone	Gender
Appointment Reminder Contact Preference: <i>I authorize the following to be called for appointment reminders</i> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Do Not Contact <input type="checkbox"/>					
Employer Name		Employer Address, Phone		Patient Email Address: <i>I Authorize use for receipt of patient statements and patient satisfaction surveys.</i> <input type="checkbox"/>	
Marital Status (Circle One) Single / Married / Divorced Widowed / Separated		Employment Status (Circle One) Full Time / Part Time Not Employed / Self Employed Retired / Military Duty		Student Status (Circle One) Full Time / Part Time Not a Student	

Last Name		First Name		MI	Patient Relationship to Guarantor	
Address			City	State	Zip Code	
Home Phone		Work Phone		Cell Phone		
Gender	Birth Date	Social Security No.		Employer Name		
Employer Address		Employer Phone		Guarantor Email Address: <i>I Authorize use for receipt of patient statements and patient satisfaction surveys.</i> <input type="checkbox"/>		

Emergency Contact	Home Phone	Work Phone	Emergency Contact Relationship to Patient
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Fill in if no copy of card

Insurance Name		Claims Address		Insurance Name		Claims Address	
City, State, Zip		Ins Ph. No.		City, State, Zip		Ins Ph. No.	
Effective Date	Exp Date	Subscriber Birth Date		Effective Date	Exp Date	Subscriber Birth Date	
Subscriber Name		Policy No.		Subscriber Name		Policy No.	
Subscriber Address		City, State	Zip	Subscriber Address		City, State	Zip
Subscriber SSN	Subscriber Employer			Subscriber SSN	Subscriber Employer		
Group Name «PL1GroupName»		Group No. «PL1GroupNo»		Group Name «PL2GroupName»		Group No. «PL2GroupNo»	
Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			

Race (Circle all that apply) Entered: American Indian/Alaskan Native Asian Black/African American Native Hawaiian Other Pacific Islander White Decline to Report	Ethnicity (Circle One) Entered: Hispanic/Latino Non-hispanic/Non-Latino Decline to Report Do you need an interpreter? Yes / No	Primary Language (Circle One) Entered: English Spanish Chinese Russian Other: _____
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How did you hear about us?

Have you been seen here before? Yes / No	Primary Care Physician «PCPName»
Is this visit due to a work-related illness/injury? Yes / No	If yes, please list the employer's name
What is your pharmacy's name and location?	

**Authorization To Pay Benefits To Provider:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider when he accepts assignment.

**Authorization To Release Medical Information.** I hereby authorize my Provider to release any information necessary for my course of treatment.

I have reviewed the information above and made any necessary changes. \_\_\_\_\_ (patient/guardian initial)

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date