Full Name: _____ **DOB:** _____

Social Security #: _____ **Gender (circle one):** Male Female

Race (circle one): American Indian/Alaska Native Asian African American/Black

Native Hawaiian/Other Pacific Islander White Other: _____

Ethnicity: Hispanic Non-Hispanic

Marital Status (circle one): Single Married Divorced Separated Widow

Address: _____

Street City State Zip

Preferred Phone Number: _____ Home/Cell/Work

Email Address: _____ I would like to be web-enabled ☐ Yes ☐ No

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Emergency Contact Information

Full Name: _____ **Relationship to patient:** _____

Contact Phone Number: _____

Insurance Information

(**Only** complete if you do not have your insurance card)

Insurance Company: _____ **Member ID:** _____

Group Number: _____ **Copayment:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR COPAYS, DEDUCTIBLES AND COINSURANCES, AS WELL AS NON-COVERED SERVICES, AS DETERMINED BY MY CONTRACT WITH MY INSURANCE CARRIER. I AGREE TO PAY THE AMOUNT DUE AFTER MY INSURER HAS MADE PAYMENT TO MY PROVIDER.

Patient or Guardian' Signature: _____ **Date:** _____

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