PATIENT INFORMATION

Patient Name: _____ Sex: Male Female

Race: _____ Ethnicity: _____ Preferred Language: _____

Date of Birth: _____ SS#: _____ Email Address: _____

Address: _____City, State, Zip_____

Home Phone #: _____ Cell Phone # _____

Employer Name: _____ Employer Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Marital Status: (circle one) Married Single Divorced Widowed

Preferred Pharmacy Used: _____

Emergency Contact: Not Living In Household:

Name:_____ Address:_____

Telephone No:_____

INSURANCE/ GUARANTOR INFO:

Primary Insurance Company: _____

Policy #: _____ Group Name/#: _____

Guarantor Name: _____ Address: _____

Date of Birth: _____ SSN: _____

Telephone No: _____ Employer Name: _____

Secondary Insurance Company: _____

Policy #: _____ Group Name/#: _____

AUTHORIZATION TO RELEASE INFORMATION:

The Clinic may disclose all or part of this patient's record to any insurance company, association or the Federal or State Government as may be necessary for the completion of all clinic claims.

I understand that the information to be released may include information pertaining to mental and/or drug or alcohol abuse. A copy shall be as valid as the original.

_____ _____

Patient Signature Date **PLEASE SEE OTHER SIDE**