



PLEASE CLEARLY PRINT ALL PATIENT INFORMATION

Today's date: _____

Last Name: _____ First Name: _____ MI: _____

Gender: Male or Female Date of Birth: _____ Age: _____ SS#: _____

Home Address: _____ Unit or Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ - _____ - _____ Ok to leave voicemail on home phone: YES or NO

Cell Phone #: _____ - _____ - _____ Ok to leave voicemail on cell phone: YES or NO

Confidential Email Address: _____ Primary Care Physician: _____

Pharmacy Used: _____ Pharmacy Location: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Race (PLEASE CIRCLE): Am Indian or Alaska Pacific, Asian, Black African Am, White, or Other Ethnicity: Hispanic or Latino or Other

Reason for visit: _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ Insurance ID: _____ Group: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Secondary Insurance: _____

GUARANTOR SECTION-COMplete IF PATIENT IS UNDER THE AGE OF 18

Guarantor Name (person financially responsible): _____ Relationship: _____

Address (if different from patient): _____ Unit or APT#: _____

City: _____ State: _____ Zip Code: _____

FINANCIAL POLICY (We accept credit or debit cards, cash. Personal checks are not accepted.)

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign endurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any. Please indicate method of payment for today's visit: Cash Credit Card Medicare Insurance

In order for us to service your account or to collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by text/email. By initialing, I acknowledge that I have read this disclosure and agree that you may contact me as described above. X _____

I, the undersigned, consent to the care and treatment by the attending Physician, his/associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

I have reviewed the Notice of Privacy as provided at registration and understand that I may request a copy of the policy at any time.

Signature: _____ Date: _____