Please Complete All Portions

Today's Date:_____

Patient's Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____

Home Phone:_____

Cell Phone:_____Work:_____

Birth Date:_____ Age:_____ Sex:_____

Patient's Social Security Number:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Pharmacy name:_____City:_____Phone:_____

Local Friend or Relative to Contact in Case of Emergency

Name:_____ Phone:_____

Primary Care Doctor:_____ Phone:_____

Language_____

Race: White_____Black/African American_____Asian_____American Indian/Alaska Native_____
Native Hawaiian/Other Pacific Islander_____ Other_____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____

HIPAA POLICIES

Do you give our office permission to leave messages at home regarding test results as well as appointments? YES NO

With family members? YES NO With friends or others? YES NO

Authorization of pay benefits to physician: I hereby authorize payment to be made directly to my physician for medical and/or surgical benefits, if any, otherwise payable to me for his services and all future claims. A copy of this authorization shall be as valid as the original. I also hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

Signature:_____ Date:_____