First Name:_____

Middle Name:_____

Last Name:_____

Date of Birth:_____/_____/_____

Social Security #:_____-_____-_____

Gender(circle) Male Female Decline

Street Address: _____

City: _____State:____ Zip:_____

Cell #:(_____)_____-_____

Other #:(_____)_____-_____

email_____@_____

Employment Status (circle) Employed Unemployed

Student Retired Decline

Occupation:_____

Marital Status (circle) Single Married Divorced

Separated Widowed Decline

Race/Ethnicity (circle) American Indian Asian

African American Native Hawaiian White Decline

Other:_____

Language Preference (circle) English Spanish Decline

Other:_____

Today's visit is (circle) Office Visit Nurse Visit

Work Related Injury Motor Vehicle Accident(MVA)

Date of Work Injury or (MVA):_____/_____/_____

State of MVA (circle) NC or other _____

Reason for Today's Visit:_____

Pharmacy:_____

Pharmacy location:_____

Pharmacy Phone #:(_____)_____-_____

Name of Primary Insurance Company:

_____

Insurance card #_____

Group #_____

Who is responsible for insurance (Circle)

Self Mom Dad Spouse

IF NOT SELF (We have your info on the first page):

Name of Responsible Party_____

Patient relationship to Insured (circle)

Spouse Daughter Son Legal Dependent

Step Daughter Step Son

Phone#:(_____)_____-_____

Date of Birth:_____/_____/_____

Social Security #:_____-_____-_____

Responsible Party Address:

_____

City: _____State: _____ Zip: _____

Name of **Secondary Insurance** Company:

_____

Insurance card #_____

Who is responsible for insurance (Circle)

Self Mom Dad Spouse

Name of Responsible Party_____

Patient relationship to Insured (circle)

Spouse Daughter Son Legal Dependent

Step Daughter Step Son

Phone#:(_____)_____-_____

Date of Birth:_____/_____/_____

Social Security #:_____-_____-_____

Responsible Party Address: _____

City: _____State: _____ Zip: _____

If you have Tertiary Insurance please notify the front desk