

REASON FOR VISIT

PATIENT INFORMATION

Name		Date of Birth	Sex
Address		City	State Zip
Home Phone		Work	Cell
Email Address	Social Security Number	Ok to Leave message at Home, Work, or Cell number? <input type="radio"/> Yes <input type="radio"/> No Which number?	
Employer Name/Address		Student Status <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Not a Student	
Race <input type="radio"/> Black/African American <input type="radio"/> Asian <input type="radio"/> Caucasian <input type="radio"/> Hispanic or Latino <input type="radio"/> Other (Please Specify)			
Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic <input type="radio"/> Decline to Provide		Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widow	
Primary Language Spoken in the Home <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other (please define):		Veteran <input type="radio"/> Yes <input type="radio"/> No	Smoker <input type="radio"/> Yes <input type="radio"/> No
Emergency Contact Name/ ADDR		Relationship	Phone
Primary Care Doctor: Name, Address & Phone			
Preferred Pharmacy: Name, Address & Phone			

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE
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NAME	Date of Birth	Relationship to Patient
Address	City	State Zip
Phone	Home/Cell	Work Social Security #:

PRIMARY INSURANCE

Insurance Company Name	Phone Number	
Policy Number/Member ID Number	Group Number	
Name of Insured	Date of Birth	Relationship to Patient <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other

SECONDARY INSURANCE IF APPLICABLE
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Insurance Company Name	Phone Number	
Policy Number/Member ID Number	Group Number	Relationship to Patient <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other

HOW DID YOU HEAR ABOUT US?

Existing Patient (Please Specify) _____ Family Referral (Please Specify) _____
 Insurance Billboard/Drive By Employee Direct Mail Hospital Referred Internet Living Magazine Other _____

With which lab is your insurance contracted (accepts)-? LabCorp Quest CPL Other (please define): _____
 Please note: labs may be drawn in the office. However, it is your responsibility to know which lab your insurance accepts. Call your insurance prior to having blood work drawn to make sure that they will cover testing. **We are not responsible for third party bills related to services rendered.**

I certify that I have carefully reviewed this document, understand it, and have completed it truthfully.

Signature of Patient or Guardian

Date