PATIENT INFORMATION

First Name __________________________ Mid Init ______ Last Name ________________________________

Address ________________________________City_________________ State ________________Zip________

Home Phone ____________________ Cell Phone ____________________ Work Phone ___________________

SS# __________________ DOB: _________ Age: ______ Email Address _______________________________

Employer's Name ___________________________ Address ____

Occupation _____________________________ **REFERRING PHYSICIAN_____________________________**

Phone _________________Primary Care Physician __________________________Phone ________________

INFORMATION OF PERSON RESPONSIBLE FOR BILLING

First Name __________________________ Mid Init _____ Last Name _________________________________

Address ____

Home Phone ______________________ Cell Phone ____________________ Work Phone _________________

Employer's Name ___________________________ Address ____

Email Address ______________________________________ (**To be used only if phone contact not available)**

Name and phone of nearest friend or relative not living with you _______________________________________

INSURANCE INFORMATION

Medicaid # ____Medicare # _______________________________

BCBS # ________________________ Grp # ___________________DOB of policy holder __________________

Other ____

Preferred Pharmacy ____________________________________City___________________________________

Phone ____Fax ___________________________________

**** Note** – All prescriptions will be sent to this pharmacy until patient notifies of a change.

(over)

CIRCLE EACH THAT APPLIES:

Birth Sex: Male or Female

Sexual Orientation: Lesbian, gay or homosexual, Straight or heterosexual, Bisexual, choose not to disclose, other________ _________________, do not know.

Gender Identity: Male, Female, Female to Male (FTM)/Transgender Male/Trans Man, Male-To-Female (MTF) Transgender Female/Trans Woman, Genderqueer, neither exclusively male or female, Choose not to disclose, Additional gender category or other, please specify ________________________________

Employment: Employed, Unemployed, Retired, Student

Marital Status: Married, Single, Divorced, Widowed

Race: Caucasian, African American, Hispanic, Middle Eastern, Near Eastern, Other _____________________

How would you like to be addressed? ____

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits to the party who participates with my insurance.

Signature: ____ Date ____________________

I understand the providers charge may exceed the insurance payments, and if greater than such payment, I will be responsible for that amount **only on non-participating insurances.**

Signature: ____ Date ____________________