PATIENT INFORMATION SHEET

Name: _____ Social Security #: _____

Date of Birth: _____ Sex (circle one): Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Cell Phone # _____

Pharmacy Name & Location _____

May we text you for appointment reminders? Yes _____ No _____

Do you want access to the patient portal? Yes _____ No _____

Email Address for Patient Portal: _____

Employment Status: Full-Time _____ Part-Time ____ Unemployed ____ Retired ____ Student ____

Name of Employer: _____ Work Phone: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Race Origin: African American ____ Asian ____ Caucasian ____ Hispanic ____ Other Race ____

INSURANCE INFORMATION

Primary Insurance: Self _____ Spouse _____ Parent _____

Name of Insurance Company: _____

Policy #: _____ Group #: _____

If this policy is under your spouse/parent please fill out this section below with their information

Spouse/Parent Name: _____ Date of Birth: _____

Social Security #: _____ Place of Employment: _____

Secondary Insurance: Self _____ Spouse _____ Parent _____

Name of Insurance Company: _____

Policy # _____ Group # _____

EMERGENCY CONTACT

Contact Name: _____ Phone # _____ Relationship: _____

Signature: _____ Date: _____

Please Print & Bring to Office for your appointment.