PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First MI)	Date of Birth ___/___/___	Age	Marital Status	Today's Date ___/___/___
Address (Street Address)	City - State - Zip Code		Social Security No.	
E-mail Address	Home Phone (_____) _____-_____		Cell Phone (_____) _____-_____	
Parent: If under 18	Date of Birth ___/___/___	Social Security No.	Home Phone (_____) _____-_____	
Employer Name	Occupation		Work Phone (_____) _____-_____	
Employer Address (Street Address)	City - State - Zip Code			
Nearest friend not living with you	Address (Street - City - State - Zip		Home Phone (_____) _____-_____	
Nearest relative not living with you	Address (Street - City - State - Zip		Home Phone (_____) _____-_____	
Emergency Contact	Relationship		Phone (_____) _____-_____	

Who is financially responsible for this bill?

How will this bill be paid today?

PHARMACY INFORMATION

PLEASE COMPLETE BOTH PHARMACY CHOICES BELOW:

Local Pharmacy: Phone Number:_____ Fax Number: _____

Name:_____ Address:_____ City:_____ State:_____

Mail Order Pharmacy: Phone Number:_____ Fax Number: _____

Name:_____ Address:_____ City:_____ State:_____

INSURANCE INFORMATION

Primary Insurance Name	Address (Street - City - State - Zip		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. Number	I.D. Number

IF INSURED IS SPOUSE, PLEASE FILL IN THE FOLLOWING INFORMATION

Spouse's Name (Last, First MI)	Date of Birth ___/___/___	Social Security No.	Spouse's Work Phone (_____) _____-_____
Secondary Insurance Name	Address (Street - City - State - Zip		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. Number	I.D. Number