

PATIENT INFORMATION

Name		Date of Birth	Sex
Address		City	State Zip
Home Phone		Work	Cell
Email Address		Social Security Number	
Preferred Pharmacy (Name / Address / Phone Number):			
Employer Name and Address:		Student Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> N/A	
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"/> Widowed/Widower	
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

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

NAME		Date of Birth	Relationship to Patient
Address		City	State Zip
Phone Home/Cell		Work	Social Security Number:

PRIMARY INSURANCE

Insurance Company Name		Phone Number
Policy Number/Member ID Number	Group Number	
Address		City State Zip
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

Insurance Company Name		Phone Number
Policy Number/Member ID Number	Group Number	
Address		City State Zip
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

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 _____

Which lab is your insurance co. contracted with? LabCorp Quest CPL Other (please define): _____

Please note, that we may draw labs in the office; however, it is your responsibility to know which lab your insurance co. is contracted with. Please call your insurance co. prior to having blood work drawn to make sure that they will cover testing for the appropriate CPT codes. We are not responsible for third party bills related to services rendered.

I certify that I have carefully reviewed this document, understand and have filled out truthfully.

 Signature of Patient or Guardian (Relationship to Patient, If not signed by the Patient) _____
Date