PATIENT DEMOGRAPHIC PAGE

BIRTHDATE	SEX M F	MARITAL STATUS M D S W

LAST NAME	M I	FIRST NAME

STREET ADDRESS	CITY	ZIP

HOME NUMBER	CELL NUMBER	WORK NUMBER	E-MAIL

PHARMACY NAME & LOCATION	PHARMACY NUMBER

HOW DID YOU HEAR ABOUT US? ____________________

RACE: (Please circle.)
WHITE AFRICAN AMERICAN HISPANIC NON-HISPANIC ASIAN OTHER____________________

PRIMARY LANGUAGE: (Please circle.)
ENGLISH SPANISH CHINESE FRENCH ARABIC SIGN

ETHNICITY: (Please circle.)
HISPANIC NON-HISPANIC OTHER____________________

DO YOU HAVE AN ADVANCE DIRECTIVE / POWER OF ATTORNEY? ____ ***YES*** ____ ***NO***

If yes, please provide or allow our office to obtain a copy for your record.

EMERGENCY CONTACT PERSON	RELATIONSHIP	CONTACT NUMBER

By signing this form, you authorize us to process your insurance claim and release any information required to process your claim. Please understand that you are responsible for all insurance rejections, deductibles, copays and any non-payment claims by your insurance carrier. You are also responsible for maintaining current insurance information on file.

PATIENT SIGNATURE ____

IF UNDER 18 YEARS OF AGE, PLEASE PROVIDE PARENT SIGNATURE

PLEASE PROVIDE COPIES OF INSURANCE CARDS AND PHOTO ID TO FRONT DESK.