PATIENT DEMOGRAPHIC PAGE

BIRTHDATE	SEX	MARITAL STATUS
	M F	M D S W

LAST NAME	MI	FIRST NAME

STREET ADDRESS	CITY	ZIP

HOME NUMBER	CELL NUMBER	WORK NUMBER	EXT#

PHARMACY NAME AND 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 ADVANCED DIRECTIVE/POWER OF ATTORNEY? YES NO

IF YES, PLEASE ALLOW OUR OFFICE TO OBTAIN A COPY FOR YOUR RECORD

EMERGENCY CONTACT PERSON	RELATIONSHIP	CONTACT NUMBER

IS THIS VISIT THE RESULT OF AN AUTO ACCIDENT OR WORKMANS COMP CLAIM? YES NO

IF YES, PLEASE SUPPLY FOR FOLLOWING INFORMATION

AUTO INSURANCE COMPANY/EMPLOYER	PHONE NUMBER

NAME OF INSURANCE ADJUSTER	CLAIM NUMBER	ACCIDENT DATE

By signing the form, your 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 maintaing 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