Patient Name: ____________________________________**Date of Birth**: _______________________

Address: ____

City, State, Zip: ____

Home Phone #: _____________________________ **Work #** ___________________________________

Cell # ___________________________________ **Social Security #** ______________________________

Employer: ________________________**Email**: ____

Sex: [ ] Female [ ] Male **Ethnicity**: ☐ Hispanic or Latino ☐ Other

Language Preferred: ____________________ **Race**: ☐ American Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ White ☐ Asian ☐ Other _____________

Referring Doctor: ___________________________**Primary Doctor**: ____________________________

Preferred Pharmacy: __________________________

Emergency Contact: ____

Emergency Phone: ____

Primary Ins: ______________________ **Secondary Ins**: ______________________________

Policy Holder: ______________________ **Relationship**: _______________________________

Parent Information (if patient is a minor) Name: ____________________________________

DOB: ___________________ SSN: ________________________ Employer: __________________

Work Phone: ____________________________ Cell phone: ____________________________________

Check-Out Note:
Please stop at the check-out counter before leaving our office. Payment for office copays are due on the day of service and balances due upon receipt. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept prior to being examined.

Release of Information and Assignments of Benefits Declaration:
I hereby authorize release of any medical information necessary to process my insurance claim and also assign to the doctor all payments from Medicare and/or other insurance provider(s) for services rendered. I further agree to obtain any referrals necessary for today’s visit and any future visits. I understand and agree to the above conditions.

Date: ________________________ Signature: ____