MARKS Please Print

PRIMARY CARE PHYSICIAN _____ **PHARMACY & STREET**_____

PATIENT'S NAME: _____ **SEX:** ❑ **Female** ❑ **Male**

(Last) ***(First),*** ***(MI)***

PREFERRED NAME _____ **Date of Birth** _____ **SSN:** _____

RACE: (Please check one)

❑ AMERICAN INDIAN ❑ BLACK/AFRICAN AMERICAN ❑ WHITE

❑ ASIAN ❑ OTHER_____ ❑ DECLINED

ETHNICITY: (Please check one)

❑ HISPANIC/LATINO ❑ DECLINED

❑ NOT HISPANIS/LATINO

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

Address:_____ **City/ State/Zip:** _____

PHONE: Home _____Work _____Cell_____ Primary_____

Employer: _____ **Occupation:** _____

Email:_____

May we email you? ❑ YES ❑ NO

PREFERRED COMMUNICATION: ❑ MAIL ❑ E-MAIL PHONE: ❑ CELL ❑ HOME ❑ WORK

SPOUSE ***/ Parent or Guardian if minor***

Name: _____**Date of Birth:** _____ **SSN:**_____

Address: _____ **PHONE: Cell** _____**Work** _____

Employer _____ **Occupation** _____

EMERGENCY CONTACT (*PERSON NOT LIVING WITH YOU*)

Name:_____**Relationship** _____

Phone#: _____ **Address:** _____

PRIMARY INSURANCE _____

Address _____**City/State/Zip** _____

ID# _____**Group#** _____

Insured's Name_____ **Date of Birth** _____ **Relationship** _____

SECONDARY INSURANCE _____

Address _____ **City/State/Zip** _____

ID#_____ **Group #**_____

Insured's Name _____**Date of Birth** _____**Relationship** _____

I AUTHORIZE THE RELEASE OF ANY PERSONAL HEALTH INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR SERVICES RENDERED AND ANY OTHER AVENUES USED FOR COLLECTION OF BALANCES. I AUTHORIZE ANY BENEFITS ON MY BEHALF AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE PRACTICE. I AUTHORIZE ACCESS TO THE PHARMACY BENEFIT MANAGER, PBM, AS NEEDED BY MY PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. UPON REQUEST, IF I SHOULD RECEIVE PAYMENT FROM MY INSURANCE COMPANY, I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR MY CO- PAYMENT, DEDUCTIBLES OR BALANCES AS DETERMINED BY MY INSURANCE CARRIER. I HAVE BEEN INFORMED OF THIS OFFICE'S HIPAA POLICY AND OFFERED A COPY OF SUCH.

SIGNATURE _____ **DATE** _____