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Patient Information

Patient Name:	First	Middle Initial	SS	N:	D	OOB:	_ Sex:
		Middle Initial	Last				
Mailing Address:			City:		State:	Zip Code:	
Iome Phone:	C	Cell Phone:	Work:	Email:			
mployer:		Address:		Cit	y:	_ State: Zip Code	:
mergency Contact:			Phone Number:		Relation to Pa	tient:	
rimary Care Provider: _							
referred Pharmacy:			Address/ or Cro	ss Streets			
onsent to pull pharmac	y medication l	history? Yes No	_				
ace:		Ethnicit	y: Hispanic or Latin	☐ Not Hispanic o	or Latin	☐ Refuse to Report	
rimary Language:				_ Limited English Pro	oficiency: Yes_	No	
Vho referred you to our	clinic or how	did you hear about us?				Veteran: Yes	No_
		Pa	rents or Guardians (If Minor)			
		Га		, ,		AOD.	C
Jame:	First	Middle Initial	Last	N:	L	OOB:	_ Sex:
failing Address:			City:		State:	Zip Code:	
Iome Phone:	C	Cell Phone:	Work:	Email:			
ddress:		City: _	State	: Zip Code: _	F	Relation to Patient:	
Vame:			SS	N:	D	OOB:	_ Sex:
	First	Middle Initial	Last			MM/DD/YYYY	
failing Address:			City:		State:	Zip Code:	
ome Phone:	C	Cell Phone:	Work:	Employ	yer:		
.ddress:		City: _	State	: Zip Code: _	F	Relation to Patient:	
			Insurance-Prim	ary			
nsurance Name:			ID Number:				
ubscriber Name:				SSN:		DOB:	
	First	Middle Initial	Last			MM/I	DD/YYYY
			Insurance-Second	dary			
nsurance Name:			ID Number:		_		
ubscriber Name:				SSN:		DOB:	
	First	Middle Initial	Last			MM/I	DD/YYYY

I authorize treatment of the named above and agree to pay all fees and charges for such treatment. I agree to pay all for myself and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed apon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/We agree to pay reasonable attorney's fees or such cost as the court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pend ency of claims thereon, all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

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Signature:	(1)	pe first and last name if electronic signature)	Da	lC