FOR OFFICE USE ONLY

PATIENT INFORMATION

ACCT#__________________
INITIALS__________________

DATE__________________

First Name:______________________________ Middle Initial:________ Last Name:______________________________

Nickname:______________________________ Sex: ☐ Male ☐ Female Date of Birth:________________ SS#______________________

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow/Widower ☐ Single

Home Address:____ Apt #:________________

City:______________________________ State:______________________________ Zip Code:________________

Home Telephone: (_____) ______________________________ Cell Phone: (_____) ______________________________

Email Address:____

Pharmacy Name:____ Pharmacy Phone #: (_____) ____________________

Pharmacy Address (Including City, State and Zip Code):____

Referred By:______________________ Your Dentist's Name:______________________ Your Physician's Name:______________________

Employed: ☐ Full Time ☐ Part Time ☐ Retired Employer Name:______________________________

Address:______________________________ City:______________________ State: ________ Zip:______________

Business Telephone: (_____) ______________________________ Extension: ______________________________

PERSON TO CONTACT IN CASE OF EMERGENCY

First & Last Name:____

Home Address:______________________________ City:______________________ State:______ Zip:______________

Home Phone#: (_____) ____________________ Cell Phone #:(_____) ____________________ Work Phone #: (_____) ____________________

IF PATIENT IS UNDER 18 YEARS OF AGE PLEASE COMPLETE BELOW FOR LEGAL GUARDIAN INFORMATION

Name:____ Relationship:______________________

Date of Birth:________________ Sex: ☐ Male ☐ Female Social Security #:______________________________

Home Address:______________________________ City:______________________ State: ______ Zip:______________

Home Phone #:(_____) ____________________ Cell Phone #:(_____) ____________________ Work Phone #: (_____) ____________________

Employer:______________________ Address:____

POLICY HOLDER INSURANCE INFORMATION

Policy Holder Name:____ Date of Birth:______________________

Policy Holder Address:______________________________________ City:________________ State:______ Zip:__________

Insured ID #:______________________________ Group Name:____