***** Please note all information is required *****

NAME: _____
Last First Middle

Mailing Address: _____
Street Apt #

_____
City State Zip

(_____)_____ (_____)_____ (_____) _____
Home Cell Other

Contact Preference: Home Cell Other Email:_____

DOB: _____/_____/_____ SSN: _____-_____-_____ Race/ Ethnicity: _____

Marital Status: _____ Language:_____

Pharmacy Name / Location:_____

Employer:_____ Occupation:_____

Emergency Contact: _____
Name Relationship Phone#

Primary Physician: _____ Referring Physician:_____

INSURANCE WAIVER

If my insurance denies payment for any services not covered or not authorized, I am personally and full responsible for payment.

Insurance Company:_____
Name PPO/ HMO

Subscriber Name:_____Relationship: _____

Subscriber SSN : _____-_____-_____ DOB: _____ / _____ / _____

Secondary Insurance? Yes / No Insurance Company: _____

Subscribe Name: _____ Relationship: _____

Subscriber SSN : _____-_____-_____ DOB: _____ / _____ / _____

******* OFFICE POLICY *******

$25.00 No Show / Same day Cancellation Fee. $25.00 fee for all returned checks
$20.00 per each disability form, Please allow 7-10 business days for completion of forms
$10.00 charge will apply for co-pays not made at time of appointment.

Patient Signature: _____ Date: _____

Patent/ Guardian: _____ Date:_____