# WELCOME

PATIENT INFORMATION:(PLEASE USE FULL LEGAL NAME)

Last Name:_____ First Name:_____ MI___ Preferred Name_____

Address_____ SS #_____RACE_____

City_____ State_____ Zip_____

Preferred Phone# (_____)_____Alternate Phone # (_____)_____

Date of Birth_____ Age _____ Sex:_____ Email_____

Emergency Contact Name_____ Emergency Phone_____

PHARMACY_____ PORTAL ACCESS: PAPER OR PORTAL

PARENT INFORMATION: (PLEASE USE LEGAL FULL NAME)

***PERSON RESPONSIBLE FOR BILL: _____MOTHER _____ FATHER _____ OTHER

RESPONSIBLE PERSON'S NAME_____DOB _____SS_____

ADDRESS (if different) _____ Phone # (_____)_____

PARENT'S NAMES_____

PAITENT'S SIBLINGS NAMES_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:

POLICY HOLDER'S NAME: _____ INSURANCE NAME_____

POLICY HOLDER'S SS#:_____ POLICY HOLDER'S DOB_____

POLICY/ID # _____ GROUP # _____ EFF DATE_____

CLAIMS ADDRESS & PHONE:_____

SECONADRY INSURANCE:

POLICY HOLDERS'S NAME:_____ INSURANCE NAME_____

POLICY HOLDER'S SS#:_____ POLICY'S HOLDER DOB_____

POLICY/ID #_____ GROUP #_____ EFF DATE _____