PATIENT INFORMATION FORM

Please Print

_____ _____ _____ _____

Last Name First Name Middle Initial Suffix

_____ _____ _____

Home Phone Cell Phone Work Phone

_____ _____

Home Address City, State, and Zip Code

_____ _____ Male or Female

Date of Birth Social Security Number Sex

Pharmacy: _____ Street: _____City: _____

The following information is collected as required by US Government regulations:

Race: □ White □ Black □ Hispanic □ Asian □ Other: _____

Primary Language: □ English □ Spanish □ Other: _____

_____ _____ □ Retired

Employer Occupation

Who may we contact in case of emergency? _____ _____

Name Phone

Who may we thank for referring you? _____

Name

Who is your primary physician? _____

Name

Information of Person Responsible for Bill or having primary or secondary insurance if not the patient.

_____ _____ _____ _____

_____ _____ _____

Home Phone Cell Phone Work Phone

_____ _____

Home Address City, State, and Zip Code

_____ _____ _____ _____

Date of Birth Social Security Number Employer Occupation

I will be paying today by □ cash □ check □ Credit Card

Do you have a Health Savings Account □ YES □ NO

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE