Patient Information Sheet

Chart# ________________ Primary Doctor: ________________________ Referred By: ________________

Pharmacy Name & # ____

Patient Name: ______________________ Sex ____ DOB __/__/__ SSN# ________________________

Ethnicity: ❑ Caucasian ❑ African-American ❑ Native American ❑ Hispanic ❑ Asian ❑ Other

Patient Name: ______________________ Sex ____ DOB __/__/__ SSN# ________________________

Ethnicity: ❑ Caucasian ❑ African-American ❑ Native American ❑ Hispanic ❑ Asian ❑ Other

Patient Name: ______________________ Sex ____ DOB __/__/__ SSN# ________________________

Ethnicity: ❑ Caucasian ❑ African-American ❑ Native American ❑ Hispanic ❑ Asian ❑ Other

Patient Name: ______________________ Sex ____ DOB __/__/__ SSN# ________________________

Ethnicity: ❑ Caucasian ❑ African-American ❑ Native American ❑ Hispanic ❑ Asian ❑ Other

Patient Name: ______________________ Sex ____ DOB __/__/__ SSN# ________________________

Ethnicity: ❑ Caucasian ❑ African-American ❑ Native American ❑ Hispanic ❑ Asian ❑ Other

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Home Address: ____

City: ____________________ State: ______ Zip: __________________

Home Phone: ___________________ Emergency Contact: _____________________

Cell Phone: (father) _________________ Cell Phone: (mother) _________________

Parents Marital Status: M S D W

Email Address: ____

If parents separated /divorced. Information for patient's non-primary residence:

Name: ____

Address: ____

City: ________________________ State: ____ Zip: ___________

Phone: ____

Father: Name: ________________________ DOB: ___________ SSN: ______________________

Employer: _________________________ Work Phone: ______________________________

Work Address: ____

Mother: Name: ________________________ DOB: ___________ SSN: ______________________

Employer: _________________________ Work Phone: ______________________________

Work Address: ____

Primary Insurance:

Insurance Company: _________________ ID# ________________

Subscriber Name: ___________________

Secondary Insurance:

Insurance Company: _________________ ID# ________________

Subscriber Name: ___________________

Insurance Authorization:

I authorize the release of any medical information necessary to process any claim, and request payment of medical benefits for services rendered either to myself or to the physician.

I understand that I will be held responsible for any services not covered by my insurance.

Signed: _____________________________ Dated: _____________________