

First Name Middle Initial Last Name Gender

Address Apt City State Zip

Home Phone Cell Phone E-Mail

Birth Date: Relationship to Insured:

Social Security #: Preferred Language:

Race: American Indian or Alaska Native Native Hawaiian or Pacific Islander **Ethnicity:**
 White Black or African American Asian Hispanic or Latino Not Hispanic or Latino
 Decline to Answer Decline to Answer

Nature of Problem: _____ **Date:** _____ Occupation: _____
(Date Illness First Appeared)

If You Are a Minor, Fill in Your Parent's Name : _____

Referring Physician: _____
(Name, Address & Phone # of Referring Physician)

Primary Care Doctor: _____

PHARMACY INFORMATION

Name of Pharmacy: _____ **Phone # of Pharmacy:** _____

Address of Pharmacy: _____ **Prescription Benefit ID# :** _____

INSURANCE INFORMATION

Primary Insurance

Additional Insurance

Insurance Plan/Company Insurance Plan/Company

Insurance Address: Insurance Address:

Subscriber's ID #: Subscriber's ID #:

Patient Relationship to insured Patient Relationship to insured

Name of Subscriber: Name of Subscriber:

Address of Subscriber Address of Subscriber

Phone #: Phone #:

Social Security # of Subscriber: Social Security # of Subscriber:

Birth Date of Subscriber Birth Date of Subscriber

A copy of this signature for release of information to your insurance company, for submission of claims, or a referring physician is as valid as the original.

Signed: _____ Date: _____