

**PATIENT INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

MARTITAL STATUS \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PCP \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATION \_\_\_\_\_

PHARMACY-NAME \_\_\_\_\_ LOCATION \_\_\_\_\_ PHONE \_\_\_\_\_

**DUE TO EMR MEANINGFUL USE WE ARE REQUIRED TO OBTAIN THE FOLLOWING INFORMATION:**

RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_ LAUGUAGE \_\_\_\_\_ EMAIL \_\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_ RELATION \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INS CARRIER** \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SSN \_\_\_\_\_ RELATIONSHIP TO PT \_\_\_\_\_

**SECONDARY INS CARRIER**

\_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SSN \_\_\_\_\_ RELATIONSHIP TO PT \_\_\_\_\_

NAME OF PROVIDER WHO REFERRED YOU HERE \_\_\_\_\_