**Patient Information**

Legal Name: (Last) (First) (MI)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male Female Birthdate: \_\_\_\_\_ / \_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 MM / DD / YYYY
Home Address:

City/State/Zip: Unit #:

Home Phone: Cell Phone: Work Phone:

Email:

Employer: Occupation:

 Race: Ethnicity:

 ⃝ Asian ⃝ Hispanic ⃝ Latino/Hispanic
 ⃝ Black Non-Hispanic ⃝ Native American ⃝ Other
 ⃝ White Non-Hispanic ⃝ Other ⃝ Do not want to report
 ⃝ African American Preferred Language:

**Preferred Pharmacy?** (Name/Address/Number)

Primary Care Physician Name:

How did you hear about us or who referred you?

**In Case Of Emergency Call:**

Name: Phone: Relationship:

**Guarantor Information (Parent or person responsible for account)**

Legal Name:

Relationship to Pt: Birthdate: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Sex: Male Female

Address: City/State/Zip:

Home Phone: Cell Phone: Work Phone:

**Primary Insurance Information**

Policy Holder Name: Birthdate: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Relationship to pt:

Insurance Name: Address: City/State/Zip:

**Secondary Insurance Information**

Policy Holder Name: Birthdate: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Relationship to pt:

Insurance Name: Address: City/State/Zip: