LAST Name: _____ First Name: _____

Middle Name: _____ Preferred Name: _____

Date of Birth: _____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Social Security Number: _____

Preferred Language: _____ Race: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ **Preferred Phone: ☐ Home ☐ Work ☐ Mobile**

Would you like to receive text messages? ☐ YES ☐ NO

Would you like to receive email notifications? ☐ YES ☐ NO

Email: _____ ☐ Decline to provide email address

Preferred Reminder Contact Method: ☐ Decline Reminders ☐ Text ☐ Patient Portal ☐ Phone ☐ Email

Mailing Address: _____

City: _____ State: _____ Zip: _____

Seasonal Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Pharmacy Location: _____

Primary Physician: _____ Location: _____ Phone: _____

Referring Physician: _____ Location: _____ Phone: _____

Guarantor Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Home ☐ Work ☐ Mobile

Email: _____

Emergency Contact Person: _____ Phone: _____

Caretaker Name: _____ Phone: _____

Spouse Name: _____ Phone: _____

Employer Name: _____ Occupation: _____

Primary Insurance: _____

Secondary Insurance: _____

Vision Insurance: _____