Patient information

Date_____ Name_____

Address_____ City_____

State_____ Zip_____ Home phone_____ Cell phone_____

Male____ Female_____ Date of Birth_____ Race_____

Primary Doctor_____ How did you hear about us_____

Email_____ Pharmacy name _____

Pharmacy Phone #_____

Emergency contact: Name_____ Phone_____

Social Security #_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also authorize payment of insurance benefits directly to the Doctor.

Signature_____ Date_____